LAKESHORE AREA RADIATION ONCOLOGY (LAROC)

Administrative Worksheet

Patient's Legal Name: ______________________ Date of Birth: __________ □ Male □ Female

Address/City/State/Zip: ____

Phone #: Home ______________ Cell ________________ Other ______________

E-mail address ______________________ Social Security Number ______________

Marital Status: □ Single □ Married □ Widowed □Separated □Divorced Maiden Name: __________

Name & Phone # of Spouse/ Significant Other: ______________________________

Insured Subscriber Name (if different from patient) ______________ BD ________ SS # __________

Patient Employment Status: □Disabled □Full Time □Not Employed □Part time □Retired □Self Employed □Student

Employer Name: ____

Employers Address: ______________________________ Phone ______________

Implant Device (i.e. Pacemaker/Defibrillator/Power Port) □ No □ Yes

Are you currently residing in a **Skilled Nursing Facility?** □ No □ Yes

Are you currently enrolled in **Hospice Care?** □ No □ Yes

If you answered yes to the above question please provide: Name, address and phone of facility on line below.

Facility: ____

In order to ensure that you have the best care possible, communicating with your other physicians is vital. We at (LAROC) wish to provide and/or receive documentation of services to other health care providers who may be responsible for continuing your medical care.

Please provide us with as much information as possible:

Name of primary care physician ______________________________

Address ______________________________

Phone number ______________________ Fax number ______________________

Name of surgeon ______________________________

Address ______________________________

Phone number ______________________ Fax number ______________________

Name of medical oncologist (cancer/chemo physician) ______________________________

Address ______________________________

Phone number ______________________ Fax number ______________________

Name of urologist (if applicable) ______________________________

Address ______________________________

Phone number ______________________ Fax number ______________________

Other ______________________________

Address ______________________________

Phone number ______________________ Fax number ______________________

Authorization PEOPLE INVOLVED IN PATIENT'S CARE - LAROC

Patient Name
DOB
MRN
Physician
FIN

I have the right to choose family members, friends or others to be involved in talks about my health care. The people listed below may receive any verbal information needed to be involved in my care or to help me make decisions about my care. By signing this form, I give my permission for staff within Lakeshore Area Radiation Oncology Center (LAROC) to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options and other information from previous services I have had, either in hospitals or other locations.

- I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.*
- I know that listing a person on this form does not allow them to get or copy my medical records.
- People listed on this form are not allowed to give consent for services for me.**
- For a minor, parents are assumed to be designated except for those services which the minor has given consent under Michigan law.

LIST PEOPLE THAT MAY PICK UP PRESCRIPTIONS/MEDICINES AND RECEIVE VERBAL INFORMATION ABOUT YOUR CARE

NAME OF PERSON	RELATIONSHIP	CONTACT PHONE NUMBER(S)	ALLOWED TO RECEIVE VERBAL INFORMATION ABOUT YOUR CARE	ALLOWED TO PICK UP ALL PRESCRIPTIONS
			☐	☐
			☐	☐
			☐	☐
			☐	☐

______ ☐ I do NOT wish to name anyone. (if box is checked, initial)

The following information has special protection under Michigan law and will be made available to the people listed above ONLY IF I give my approval by checking the box(es) below AND initial the line(s).

______ ☐ HIV/AIDS or other diseases – tuberculosis, hepatitis, venereal diseases, sexually transmitted diseases

______ ☐ Substance abuse services

______ ☐ Mental health services

I can update this form at any time by telling a LAROC staff member AND by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to a LAROC staff member.

PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME ________ ☐ AM/☐ PM **DATE** ________ Patient signature ____________________

☐ Patient is under 18 years of age or otherwise unable to consent because ____________________

____

TIME ________ ☐ AM/☐ PM **DATE** ________

Parent/Legal Guardian/
Patient Advocate/Next of Kin signature ____________________

*Refer to LAROC Notice of Privacy Practices.
**Other forms are required for these purposes.

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LAKESHORE AREA
RADIATION ONCOLOGY
CENTER

Patient Name
DOB
MRN
Physician
FIN

Questionnaire
PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC

Name ______________________ Today's date ____________

By what name should we call you? ______________________

Who completed this form: ☐ Self ☐ Spouse ☐ Other (specify) ____________

What is the purpose for your appointment? ______________________

MEDICATIONS

List any prescription and non-prescription medicines that you are currently taking. Include supplements, hormones, vitamins, herbs, alternative medicines

NAME OF MEDICINE	DOSE	AMOUNT EACH DAY	NAME OF MEDICINE	DOSE	AMOUNT EACH DAY

ALLERGIES

Allergic reaction to? Latex: ☐ No ☐ Yes Adhesive tape: ☐ No ☐ Yes

IV contrast: ☐ No ☐ Yes Environmental: ☐ No ☐ Yes

If yes to any of above, describe reaction ______________________

MEDICINE	DESCRIBE REACTION

PAST AND CURRENT MEDICAL CONDITIONS

Have you ever received radiation therapy? ☐ No ☐ Yes (list date, site treated and location of treating facility) ______________________

Have you ever received chemotherapy? ☐ No ☐ Yes (list date, and location of treating facility) ______________________

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OVER ➔

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

PAST AND CURRENT MEDICAL CONDITIONS *(CONTINUED)*

Have you ever had the following:

NO	YES	
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Autoimmune disorder
☐	☐	Blood clots
☐	☐	Diabetes ☐ Type I ☐ Type II
☐	☐	Diverticulosis/Colitis
☐	☐	Emphysema
☐	☐	Gallstones
☐	☐	Gastroesophageal reflux disease (GERD)
☐	☐	Heart attack/Heart disease
☐	☐	Hepatitis/Jaundice
☐	☐	High cholesterol
☐	☐	High blood pressure
☐	☐	Irregular heart rhythm
☐	☐	Kidney stones
☐	☐	Lupus
☐	☐	Obstructive sleep apnea (OSA)
☐	☐	Pacemaker
☐	☐	Previous cancers
☐	☐	Rheumatic fever
☐	☐	Scleroderma
☐	☐	Seizure
☐	☐	Stroke
☐	☐	Thyroid problems
☐	☐	Tuberculosis (TB)
☐	☐	Ulcers
☐	☐	Venous access device ☐ Power Port/CT scan compatible

Additional information ______________________________

____

List your previous surgeries: (type of surgery and body part)

Year	Surgery and where

When you are filling out this form, is it September through April? ☐ No ☐ Yes

If yes, answer these two questions :

Have you had a flu shot? ☐ No ☐ Yes

Do you plan to get a flu shot this season? ☐ No ☐ Yes

FAMILY HISTORY

If known, complete the following information about your blood relatives. For each person list age, age of death and any cancer diagnosis. For deceased, indicate cause of death. Do not include adoptive parents, siblings or children.

FAMILY MEMBER	CURRENT AGE	AGE AT TIME OF DEATH	DIAGNOSIS OF CANCER TYPE (IF ANY)	CAUSE OF DEATH IF NOT CANCER
Father				
Mother				

Do any direct family members have lupus, scleroderma or other auto-immune disorders? ☐ No ☐ Yes

If yes, explain ______________________________

____

Is there any other information about your family that you would like us to know? ______________________________

____

____

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Patient Name
DOB
MRN
Physician
FIN

PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC *(CONTINUED)*

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Number of children: ________
Do you live: ☐ Alone ☐ With spouse/family ☐ Other (describe) ________
Current living arrangement: ☐ House ☐ Apartment ☐ Nursing Home ☐ Other ________
Who do you rely on most for support/help ________
What is/was your occupation ________ Are you currently employed: ☐ No ☐ Yes

List your pharmacy (include phone number if known) ________
Do you have prescription coverage: ☐ No ☐ Yes

Have you ever made use of the following:

	AMOUNT/ TYPE	FREQUENCY	LENGTH OF USE	IF STOPPED, WHEN	DO YOU WANT INFORMATION ABOUT CESSATION/STOPPING?
Alcohol					☐ No ☐ Yes ☐ Declined
Caffeine					☐ No ☐ Yes ☐ Declined
Tobacco					☐ No ☐ Yes ☐ Declined
Recreation/ Street drugs					☐ No ☐ Yes ☐ Declined

Do you have a living will or advanced directive: ☐ No ☐ Yes
Would like information about living wills or advanced directive: ☐ No ☐ Yes ☐ Declined
While you are at our facility, do you wish to have pastoral care: ☐ No ☐ Yes ________

CONSTITUTIONAL/GENERAL SYMPTOMS

Generally speaking, have you had difficulty performing your usual daily activities? ☐ No ☐ Yes
Have you felt fatigued? ☐ No ☐ Yes
Other ________

REVIEW OF SYSTEMS

PAIN

Have you had significant pain in the past? ☐ No ☐ Yes
If yes, location ________
Do you have pain now? ☐ No ☐ Yes
If yes, location ________
Pain Rating Score ________ (0 = no pain, 10 = the worst pain you have ever had)
What helps to relieve the pain? ________
What makes the pain worse? ________
How does this pain affect you? ________
Do you feel your pain is being managed well? ☐ No ☐ Yes
If no, describe ________

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Indicate whether you have experienced the following symptoms in recent months by checking "No" or "Yes"

	NO	YES	FOR HEALTH CARE TEAM USE ONLY
CENTRAL NERVOUS ☐ **No concerns**			
Head injury with episode of "black out"	☐	☐	______
Memory loss	☐	☐	______
New or different headaches or migraines	☐	☐	______
New or different seizures	☐	☐	______
Numbness, where ______	☐	☐	______
Tingling sensation, where ______	☐	☐	______
Weakness, where ______	☐	☐	______
Other ______			
EYE ☐ **No concerns**			
Changes in your vision	☐	☐	______
Do you wear glasses/contacts	☐	☐	______
Excessive tearing	☐	☐	______
Double vision	☐	☐	______
Other ______			
EAR/NOSE/THROAT ☐ **No concerns**			
Ringing in the ear(s) ☐ Right ☐ Left ☐ Both	☐	☐	______
Diminished hearing ☐ Right ☐ Left ☐ Both	☐	☐	______
Change in voice quality	☐	☐	______
Other ______			
CARDIOVASCULAR ☐ **No concerns**			
Chest pain	☐	☐	______
Fainting episodes	☐	☐	______
Exercise intolerance	☐	☐	______
Pain in calf(s) when walking	☐	☐	______
Other ______			
RESPIRATORY ☐ **No concerns**			
Cough	☐	☐	______
Difficulty breathing	☐	☐	______
Shortness of breath	☐	☐	______
Recent upper respiratory infection	☐	☐	______
Other ______			
MUSCULOSKELETAL ☐ **No concerns**			
Any limitations in moving your joint or limb(s), describe ______	☐	☐	______
Recent falls	☐	☐	______
NUTRITION/METABOLIC/ENDOCRINE ☐ **No concerns**			
Impaired chewing	☐	☐	______
Poor intake for greater than one week	☐	☐	______
Tube feedings	☐	☐	______
Unintentional weight loss greater than 10 pounds	☐	☐	______
Unintentional weight gain	☐	☐	______
Other ______			

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LAKESHORE AREA
RADIATION ONCOLOGY
CENTER

Patient Name
DOB
MRN
Physician
FIN

PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC *(CONTINUED)*

Indicate whether you have experienced the following symptoms in recent months by checking "No" or "Yes"

	NO	YES	FOR HEALTH CARE TEAM USE ONLY
GASTROINTESTINAL ☐ **No concerns**			
Nausea	☐	☐	______
Heartburn	☐	☐	______
Diarrhea	☐	☐	______
Blood noted in your bowel movement	☐	☐	______
Blood noted while wiping your rectum	☐	☐	______
Constipation	☐	☐	______
Do you require/need anything special to move your bowels, explain ______			
Change in bowel habit or function	☐	☐	______
Other ______			
GENITOURINARY ☐ **No concerns**			
Leakage of urine	☐	☐	______
Urinating frequently	☐	☐	______
Pain with urination	☐	☐	______
Getting up at night to urinate	☐	☐	______
If yes, number of times per night ______			
REPRODUCTIVE			
For Males			
Do you have erections adequate for intercourse	☐	☐	______
For Females			
Date of onset of your last period ______			
Is there a possibility that you might be pregnant	☐	☐	______
Number of pregnancies ______			
Number of live births ______			
Have you undergone menopause, what age ______	☐	☐	______
Approximate date of your last mammogram ______			
Approximate date of your last pap smear ______			
INTEGUMENTARY ☐ **No concerns**			
Unexplained rash	☐	☐	______
Change in a mole	☐	☐	______
Abnormal nipple discharge	☐	☐	______
Breast lump	☐	☐	______
Other ______			
HEMATOLOGIC/LYMPHATIC ☐ **No concerns**			
Enlarged glands (lymph nodes)	☐	☐	______
Frequent or hard to control bleeding	☐	☐	______
Easy or excessive bleeding	☐	☐	______
Other ______			

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Indicate whether you have experienced the following symptoms in recent months by checking "No" or "Yes"

	NO	YES	FOR HEALTH CARE TEAM USE ONLY
ALLERGIES/IMMUNE			☐ See Allergy Record
Unexplained fever, within the past month	☐	☐	______
Night sweats requiring change of bedclothes	☐	☐	______
Other ______			
COPING/MENTAL HEALTH ☐ **No concerns**			
Problems falling asleep	☐	☐	______
Do you feel depressed most of the time	☐	☐	______
Thoughts of suicide	☐	☐	______
Commonly feel nervous, upset or anxious	☐	☐	______
Other ______			

Date ______ Person Completing Form signature ______

If not patient, relationship to patient ______

OFFICE USE ONLY BELOW THE LINE

Blood pressure ______
Pulse ______
Respirations ______
Temperature ______
Height ______ (inches)
Weight ______ ☐ kg / ☐ lbs
Pulse oximetry ______ ☐ Room air ☐ Oxygen ______ liters/minute

TIME ______ **DATE** ______ Physician signature ______

WHEN INFORMATION WAS ENTERED INTO ELECTRONIC HEALTH RECORD:

TIME ______ **DATE** ______ RN signature ______

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