BARBARA ANN **Karmanos**
CANCER INSTITUTE
Wayne State University

Oncology
Patient Registration

Date:____________

Diagnosis:______________

Name: ______________________________________ **I prefer to be called:** ____________
Last First MI

Date of Birth: __________ **Birthplace:** ______________ **Social Security Number:** ____________

Address: __________________ **City:**______________ **State:**_____ **Zip:** _____ **County:** __________

Home # (_____) ___________ **Cell #** (_____) ___________ **Work #** (_____)____________

Email Address__________________________

Which numbers may we use? ☐ Home ☐ Cell ☐ Work May we leave a message? ☐ Yes ☐ No

Check Appropriate Box:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Retired ☐ Disabled Occupation: ______________ Employer: ____________

Have you served in the military ☐ No ☐ Yes Where ______________ When ____________

Retirement Date: ______________

Spouse's Name: __________________________

Emergency Contact: ________________ Phone: ____________ Relationship: __________

Race: ☐ Caucasian ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Alaskan ☐ Unknown ☐ Other ________ ☐ Decline to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Advance directives: Do you have an Advanced Directive ☐ Yes ☐ No

Preferred Main Language: ☐ English ☐ Spanish ☐ Arabic ☐ Other________________

What is the highest level of education you completed?
- ☐ -8th grade or less
- ☐ -Some high school, but did not graduate
- ☐ -High school graduate or GED
- ☐ -Some college or 2-year degree
- ☐ -4-year college graduate
- ☐ -More than 4-year college degree

Whom may we thank for referring you? ______________________________________

Physician Information

Family/Primary Physician ___________________________ **Phone:** ______________

Address ___________________________ **Fax :**______________

Referring Physician: ___________________________ **Phone:** ______________

Address ___________________________ **Fax :**______________

Insurance Information

Primary Insurance

Name of Insured ______________________________DOB______________SSN# ____________________________

Relationship to Patient: Self Spouse Dependent Other

Insurance Company__________________________ Grp #____________________ ID#______________________

Secondary Insurance

Name of Insured ______________________________DOB______________SSN# ____________________________
Relationship to Patient: Self Spouse Dependent Other
Insurance Company__________________________ Grp #____________________ ID#______________________

New Patient History

Current Problem

Current Please describe briefly how your current problem started. What were your symptoms?

____

____

____

____

Cancer History

Type of your cancer: ______________________________ Date of Diagnosis: _________________________

If you have had previous treatment, please include type of treatment below:

Treatment with surgery: ☐ Yes ☐ No When & Where: ____

Radiation Therapy: ☐ Yes ☐ No When & Where: ____

Chemotherapy: ☐ Yes ☐ No When & Where: ____

Medical History

Please check if you have had any of the following medical conditions

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Disease
☐ Cancer
☐ COPD/Emphysema
☐ Depression
☐ Diabetes
☐ Gallbladder Disease
☐ Acid Reflux
☐ Glaucoma
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney Disease
☐ Pacemaker / Defibrillator
☐ Anxiety
☐ Seizures
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Heart Attack
☐ Lupus/Scleroderma

Additional Comments:____

Surgical History

Please list all surgeries, major diseases, illnesses, or conditions for which you have been hospitalized:

	Surgeries or hospitalizations	Date	Where
1	______________________	______________	______________
2	______________________	______________	______________
3	______________________	______________	______________
4.	______________________	______________	______________

Social History

Religious Belief	☐Catholic ☐Jewish ☐Protestant ☐Muslim ☐Other: ______________
Have you been exposed to:	☐Asbestos ☐Chronic Fumes ☐Chronic Dust ☐Radiation ☐Toxic Chemicals ☐Others: ______________
Alcohol Use	How many alcoholic beverages do you drink per week:_________
Smoking Status	☐ Never smoked ☐ Current Smoker: How many years have you smoked? ______________ How many cigarettes do you smoke a day? __________ ☐ Quit When did you quit? __________ How many years did you smoke? __________ How many cigarettes did you smoke per day? __________ ☐ Cigarettes ☐ Marijuana ☐ Cigars or pipes ☐ Chewing tobacco ☐Hookah ☐ Other__________

Revised 9/30/2019

FAMILY HISTORY

Include blood relatives only. Do not include anyone adopted, foster, step-relatives, or those related by marriage. List any current ages or age at time of death.

Relative	A ge	Alive Y/N?	Had Cancer Y/N?	If yes, What type?	Died of Cancer Y/N?	Other Medical Problems Y/N?	If yes, list medical problem (heart disease, diabetes, etc.)
Mother							
Father							
Mother's Mother							
Mother's Father							
Father's Mother							
Father's Father							
Daughter 1							
Daughter 2							
Daughter 3							
Daughter 4							
Son 1							
Son 2							
Son 3							
Son 4							
Sister							
Sister							
Sister							
Brother							
Brother							
Brother							
Other							
Other							

Female History

Menstrual History

Age when menstruation began? _______________

Are you still having monthly periods? □ Yes □ No

Is your menstruation slight, moderate, heavy, or irregular? _______________________

Are you presently using an IUD or birth control pills? ____________________________

Date of your last menstrual cycle: ____

Is there any possibility you could be pregnant at this time? □ Yes □ No

Menopause

If you are no longer having a menstrual cycle, at what age did your monthly periods stop? ________________

Did your menopause occur as a result of: □ Natural □ Surgery □ Following chemotherapy?

Do you experience hot flashes? □ Yes □ No

Any previous history of hormone use

Contraceptive Hormone use: □ No □ If yes, for how many years: ___________

Post Menopause Hormones: □ No □ If yes, for how many years: ___________

Pregnancies

Number of pregnancies: ____________

Number of children born alive: ______________

What was your age at your first pregnancy? _______________

Current Medication List

List all medications you are taking, including vitamins, nonprescription drugs, and herbal supplements.

Bring all Medications to your first appointment

Drug	Dose	Frequency	Ordering Physician	Date Started

Retail Pharmacy Name: ______________________________ Phone# (_______) ________-___________

Pharmacy Address: ______________________________ Fax #: (________) ________-______________

Mail Order Pharmacy Name: ______________________________ Phone# (_______) ________-___________

Do you have prescription coverage? ☐ Yes ☐ No

Allergy Information

Latex Allergy ☐ Yes ☐ No   Iodine Allergy ☐ Yes ☐ No

OTHER ALLERGY INFORMATION	REACTION	Date/Year Started

Name:______________________________ Date:______________

Authorized Patient Communication List

Patient or authorized person: I authorize any physician, hospital, or medical care facility to provide all information regarding my medical history and treatment to the Karmanos Cancer Institute. Photocopies of this form may be considered to be as valid as the original.

(Optional) Patient or authorized person: I authorize Karmanos Cancer Institute to discuss my medical condition and/or release medical information the following people (i.e. family members):

Name_______________________ Relationship__________ DOB________ Phone___________

Name_______________________ Relationship__________ DOB________ Phone___________

Name_______________________ Relationship__________ DOB________ Phone___________

Name_______________________ Relationship__________ DOB________ Phone___________

Patient Signature: ____________________________________ Date:________________

Revised 9/30/2019

Karmanos Cancer Institute Clarkston Pain/Controlled Substance Contract

The State of Michigan Opioid laws are changing. This contract is meant to outline the conditions that must be met for us to prescribe you any Pain meds, or controlled substance (CS). Some examples are **Vicodin, Xanax, Ativan, Ambien,** and pain/anxiety/sleeping pills in general.

1. Office visits for the evaluation of pain medications/CS and possible refills must be scheduled in advance. State law prohibits patients from walking into the office and demanding to be seen.
2. ***NO*** other physician (including ER docs, specialists, etc.) will be prescribing pain medications/CS.
3. You must get your medication at the **same pharmacy** every time.
4. You will take only the pain medications/CS prescribed by this office and not those belonging to friends or relatives.
5. We expect you to comply with any testing or therapy that I ordered.
6. **RANDOM DRUG TESTING WILL BE PERFORMED!** Come prepared to give a sample. Refusal or alteration/falsification of a specimen for testing is grounds for immediate discharge from the practice.
7. **PRESCRIPTIONS WILL ONLY BE PROVIDED AT THE TIME OF YOUR SCHEDULED OFFICE APPOINTMENT AND WILL NOT BE CALLED, MAILED, FAXED OR ELECTRONICALLY SENT IN.**
8. It doesn't matter how you do the math, (1-2 tabs every 4-6 hours) **ALL PRESCRIPTIONS ARE EXPECTED TO REPRESENT A 30-DAY SUPPLY, UNLESS OTHERWISE SPECIFIED. IF YOU RUN OUT EARLY, WE WILL NOT GIVE YOU ANYMORE!** Any change in condition that might require using medication at a higher rate requires office visit for approval.
9. **IF YOU MISSED YOUR SCHEDULED APPOINTMENT, YOU WOULD MISS YOUR REFILL. YOU WILL NEED AN APPOINTMENT TO GET MORE.**
10. **LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED.** Please protect your medications and yourself.
11. It is your responsibility to make sure you have the prescriptions you need and discuss any issues with the medications being prescribed before you leave the office.
12. **FAILURE TO ADHERE TO ANY PART OF THE ABOVE CONDITIONS IS CAUSE FOR IMMEDIATE DISCHARGE FROM THE PRACTICE. NO EXCUSES WILL BE TOLERATED.**

I understand that I will not be given a narcotic prescription without an office visit. I further understand that if I show up to the office without an appointment, or call the office to obtain a narcotic refill, I will be denied the refill until I come for a scheduled visit.

It is my responsibility to make sure that when I leave the office after a refill visit, that I schedule my next visit at that time.

______________________________ ______________________________

Patient Signature Date: Physician Signature Date:

We care about you.

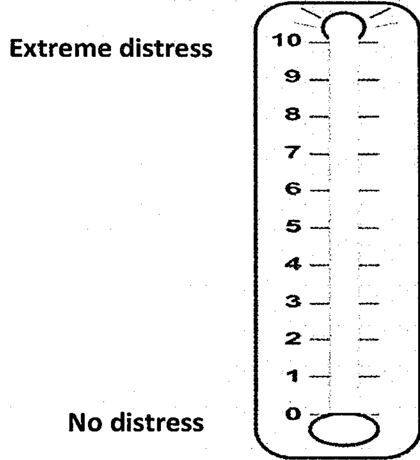
Tell us how you are feeling

Name:________________________________

Date of Birth:___________________________

Today's Date:___________________________

Instructions: Please circle the number (0-10) that best describes how much stress you have been experiencing in the past week including today



Please indicate if any of the following has been a problem for you in the past week, including today. Be sure to check YES or NO for each.

YES	NO	**Practical Problems**
☐	☐	Child care
☐	☐	Housing
☐	☐	Insurance/financial
☐	☐	Transportation
☐	☐	Work/School
☐	☐	Treatment decisions

YES	NO	**Family Problems**
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children
☐	☐	Family health issues

Please do not write below this line:

☐ **Referred to oncology social worker**

YES	NO	**Emotional Problems**
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	Feelings of abandonment
☐	☐	**Spiritual/Religious Concerns**

YES	NO	**Physical Problems**
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry/congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry/itchy
☐	☐	Sleep
☐	☐	Tingling in hands/feet

Other problems:____________________________

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Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Today's Date: ______________________

This is a screening too for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Neice/Nephew = **2nd Degree Relatives** Cousins/Great Grandparents = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary Cancer(BRCA/Colaris) in the past? YES NO

Have you ever been Diagnosed with cancer? What site: ______________________ Age: ________

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	**Self, Sibling or Child**	**YOUR RELATIONSHIP TO FAMILY MEMBER W/ CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	***EXAMPLE:*** ***Two or more relatives with a Lynch Syndrome cancer; once under age 50***				
Y	N	Have YOU been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	**Two or more** relatives on the same side of the family with any of the following, one diagnosed **before 50** (please circle): *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis*				
Y	N	**Three or more** relatives on the same side of the family with any of the following, one diagnosed **before 50**(please circle): *colon, uterine/ endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis*				
Y	N	Family member has a known Lynch syndrome mutation *if you are familiar with Lynch Syndrome it is unlikely that it exists in your family				

		BREAST AND OVARIAN CANCER (HBOC/BRAC ANALYSIS)	**Self, Sibling or Child**	**YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family member)				
Y	N	Ovarian cancer at any age (in self, first or second degree family member)				
Y	N	**Two relatives** on the same side of the family with breast cancer at any age – with **one under the age of 50**				
Y	N	**Three relatives** on the same side of the family with breast cancer **at any age**				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breast) **first cancer <50 y/o**				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family at any age				
Y	N	Anyone with Triple Negative cancer under age 60 (ER, PR and Her2 negative receptor status)				
Y	N	A family member with a known BRCA Mutation				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

____

Patient's Signature: ______________________ Date: ____________

For office use only

- ❑ Patient is appropriate for further risk assessment and/or genetic testing on ______________________
- ❑ Information given to patient to review Follow-up appointment scheduled on ______________________

Patient offered genetic testing: Accepted or Declined HCP Signature: ______________________

McLAREN HEALTHCARE

Authorization to Release Information

Patient Name ____________ Birthdate ____________ Medical Record Number ____________

Address ____________

Phone Number ____________ Maiden/Other Names ____________

I authorize MCLAREN/KARMANOS ONCOLOGY (name) **to release to** ____________ (name)

5680 BOW POINTE DR, SUTE 202 (address) — ____________ (address)

CLARKSTON MI 48346 (city,state,zip) — ____________ (city, state, zip)

248-922-6650/248-922-6655 (telephone/fax) — ____________ (telephone/fax)

____________ (email address)

Specific type of information to be disclosed: **Date(s) of Service**: ____________

- ☐ History and Physical
- ☐ Operative Report
- ☐ Physician's Notes
- ☐ Consultation Reports
- ☐ Therapy Notes
- ☐ Discharge Summary
- ☐ Laboratory Results
- ☐ Billing Records
- ☐ Home Care Records
- ☐ Diagnostic Imaging (e.g., X-Rays) reports from (date) ____________
- ☐ Diagnostic Imaging (e.g., X-Rays) films from (date) ____________
- ☐ Other ____________

Sensitive information to be disclosed: **Date(s) of Service:** ____________

- ☐ Behavioral and Mental Health Service Information (excluding Psychotherapy Notes)
- ☐ Referrals and treatment for alcohol and substance use disorder
- ☐ Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

☐ **Consent to release <u>Entire Medical Record</u>, for dates of service listed, including all information noted above:**

Date(s) of Service: ____________ ____________ **Initials** **Date**

Please continue to the otherside of this form for Acknowledgements and signatures.

840

PT.

MR.#/P.M.

DR.

By signing this form I understand:

1. That I need not sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.

2. My health information may be shared electronically.

3. The sharing of my health information will follow state and federal laws and regulations.

4. This form does not give my consent to share psychotherapy notes as defined by federal law.

5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

6. I should tell all agencies and people listed on this form when I withdraw my consent.

7. I can have a copy of this form.

8. That unless otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

9. That any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

10. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

Signature of Patient or Legal Representative ____________________ Date ____________

If Signed by Legal Representative, State Relationship to Patient ____________________

Signature of Witness ____________________ Date ____________

AUTHORIZATION TO RELEASE INFORMATION

PT.

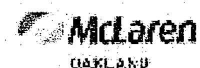
MR.#/P.M.

DR.

Oncology Functional Assessment Questionnaire

1.	My lifestyle before cancer diagnosis	☐ Active ☐ Sedentary
2.	My lifestyle since cancer diagnosis	☐ Active ☐ Sedentary
3.	I have difficulty performing my pre-cancer diagnosis household chores	☐ Yes ☐ No
4.	I have difficulty performing my job as I did prior to cancer diagnosis	☐ Yes ☐ No
5.	I have difficulty exercising for at least 30 minutes, 5 times/week	☐ Yes ☐ No
6.	I have difficulty shopping for groceries/clothes (assuming transportation is available)	☐ Yes ☐ No
7.	I have difficulty driving a car	☐ Yes ☐ No
8.	I have difficulty or shortness of breath climbing a flight of stairs at a normal pace	☐ Yes ☐ No
9.	I have difficulty lifting and carrying groceries	☐ Yes ☐ No
10.	I have difficulty walking	☐ Yes ☐ No
11.	I have difficulty preparing my own meals	☐ Yes ☐ No
12.	I have difficulty feeding myself	☐ Yes ☐ No
13.	I have difficulty dressing/undressing myself	☐ Yes ☐ No
14.	I have difficulty taking care of my own appearance (comb hair or shave)	☐ Yes ☐ No
15.	I have difficulty bathing or showering	☐ Yes ☐ No
16.	I have difficulty getting in/out of bed	☐ Yes ☐ No
17.	I have difficulty getting in/out of a chair or on/off the toilet	☐ Yes ☐ No
18.	The quality of my sleep is different from prior to cancer diagnosis	☐ Yes ☐ No
19.	Do you experience a persistent sense of tiredness that is not proportional to activity level, interferes with usual function, and is not relieved by rest?	☐ Yes ☐ No
20.	Do you experience problems with incontinence?	☐ Yes ☐ No
21.	Do you experience a heavy sensation in your arm or leg; tight fitting clothes or jewelry or shoes?	☐ Yes ☐ No
22.	Do you have any swelling in your arm, leg, trunk, head, neck or genital areas?	☐ Yes ☐ No

If you answered "yes" to any of these questions, you may be a candidate for physical therapy. You can use this questionnaire to help guide your discussion with your health care provider. If you have questions about how physical therapy can help you get your life back, call McLaren Clarkston Physical Therapy at (248) 922-6820.



Questions taken in part from: Medical Outcomes Study: 36-Item Short Form Survey Instrument and OARS Multidimensional Functional Assessment Questionnaire.
Cheville AL, Troxel AB, Basford JR, et al: Prevalence and treatment patterns of physical therapy impairments in patients with metastatic breast cancer. J Clin Oncol 26:2621-2629, 2008

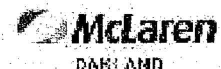
Fighting Cancer is Hard

Physical Therapy Can Help You Optimize Your Recovery

As a cancer patient and survivor, you can have a positive impact on many concerns you may experience now and in the future. Physical Therapy can help you prevent, manage, and improve the common complaints listed below:

Common Concerns:	How Physical Therapy Can Help:
Weakness/Loss of Function	Restore function through strengthening exercises
Fatigue	Improve overall energy levels through exercise
Swelling/Lymphedema	Prevent and/or reduce swelling through manual techniques and compression
Loss of Balance/Falls	Balance and coordination exercises to improve stability and sensory awareness and reduce risk of falls
Decreased Flexibility	Loosen connective tissue, stiff joints, and tight muscles through stretching and manual techniques
Scar Tissue/Cording	Manual therapy techniques and stretching can improve scar mobility leading to improvement in functional movement
Incontinence	Pelvic floor muscles can be strengthened with exercise and manual techniques
Vaginal Tightness (with or without pain)	Pelvic floor muscles can be stretched through exercise with instruction in relaxation and behavior modification
Shortness of Breath/ Decreased Endurance	Graded aerobic exercises can be performed to improve endurance
Changes in Posture	Strength and weight bearing exercises can help build or maintain bone density and reduce risk of bone injury
Numbness/Tingling	Balance and coordination exercises improve stability and sensory awareness while reducing risk of falls
Difficulty opening mouth or moving head/neck	Tight jaw and neck muscles can be elongated through manual techniques and exercise to restore function

Please fill out the attached Oncology Functional Assessment Questionnaire on the reverse side to see if physical therapy could be right for you. If you have additional questions about how physical therapy can help you get your life back, call McLaren Clarkston Physical Therapy at (248) 922-6820.



OAKLAND