Office use only: Sent by: __website___ Date:_____

USF HEALTH

University of South Florida

BYRD INSTITUTE

4001 E. Fletcher Avenue
Tampa, FL 33613

Please mail to the address above or
Fax to (813) 974-4251

New Patient Appointment Request

Thank you for your inquiry. Please complete this form and return it to the address or fax number listed above. After a doctor on our clinical team reviews the information provided, we will contact you to arrange for an appointment or to let you know of other community resources that may be applicable to your situation. Again, thank you for your interest, and for the opportunity to be of service to you.

Date Completed ____/____/____

Patient Information:

Name: _____
Last First Middle

Address: _____

City:_____State:_____Zip:_____ Phone:(_____)____-_____

Sex:_____ Age:_____ Date of Birth:____/____/____ Place of birth:_____

Marital Status: ___ Single/Never married ___ Widowed ___ Living with significant other
___ Divorced/Separated ___ Married - How many times? _____

Is the patient's primary language English?_____
If no, is the patient able to communicate in English? _____

Caregiver or Loved One Information:

Name:_____ Sex: _____

Relation to Patient: _____ Caregiver's Date of Birth:____/____/____

Phone: home (_____)_____-_____ Cell (_____)_____-_____ Work (_____)_____-_____

Address:_____
(if different from above)

_____

How were you referred to our services? (Please check all that apply.)

_____ Friend: _____

_____ Family member: _____

_____ Physician: _____

_____ Health Talk

_____ Website _____ Health Fair

_____ Community agency _____ Other (specify)_____

_____ Physician Referral Service _____

Who does the patient live with?

Lives Alone____ With Spouse only_____ With Children only_____

With Spouse and Children_____ Other_____

Which of the following best describes your residence?

_____Single-family house _____Nursing home

_____Condo _____Assisted living

_____Apartment _____Other (specify)_____

Name of the patient's primary care doctor?_____

Phone number? (____) _____-_____ fax number? (____) _____-_____

Does the patient have a problem with memory? Definitely _____ Questionable _____

In what year were problems with memory first noticed? _____

Has the problem gotten worse since then? Rapidly ___ Slowly ___ Don't Know ___ Yes No

Has the patient ever been evaluated for the problem? Yes* No

When:_____ Where: _____

By Whom: _____

Did he/she ever have a Brain CAT Scan ____; MRI Scan ____; PET scan____? Yes* No

When: ____ Where: _____

Results: _____

_____

***If yes, please bring records, discs & reports to the appointment.**

Were you told that the patient **definitely** has Alzheimer's disease? Yes No

Were you told that the patient **possibly** has Alzheimer's disease? Yes No

Were you told that the patient has some other type of memory disorder? Yes No

If yes, what?_____

What was/is the patient's occupation? _____ Year retired?_____

What was patient's highest level of education? _____

How many children does the patient have? _____

Name	Location

Is the patient in regular contact with them? Yes No

Do you have a medical Durable Power of Attorney for health care?

If yes, please bring a copy. Yes No

Please list any MEDICAL PROBLEMS the patient has, with dates if known.

_____

_____

_____

_____

_____

Is the patient currently under the care of any psychiatrist? Yes No

Please list any psychiatric **problems** the patient has?

_____

_____

_____

Has the patient been seen by a psychiatrist **at USF** within the last 5 years? Yes No

Please list any SURGERIES the patient has had below, with dates if known.

_____

_____

_____

_____

List all medicines that the patient uses. **(Include <u>ALL</u> prescription, non-prescription, vitamins, supplements and natural products**)

Current Medication	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	***500mg***	***1 pill 3x a day***

Does the patient have any drug allergies? ☐ Yes ☐ No If yes, please list name of drug and specify reaction.

	Indicate Reaction			
Name of Drug	**Rash**	**Shortness of Breath**	**Nausea**	**Other (specify)**

Does the patient drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

___Daily ___ A few days a week (specify number of days:_____)

___Less than once a week ___Never

How much does the patient drink at a time? (one drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol.) _____drinks

Has anyone ever been concerned about the patients drinking? Yes No

Has the patient <u>ever</u> use any form of smokeless tobacco (chew or snuff)? Past Current No

Has the patient <u>ever</u> smoked cigarettes? Past Current No

Does the patient currently smoke cigarettes or use smokeless tobacco?

___ Yes…If yes, how many packs per day? ___¼ ___ ½ ___1 ___1½ ___2+

___ No…If no, when did they quit? Year:_____

How many years did the patient smoke? _____

Does the patient have any of the following problems with mood or behavior? (Check all that apply)

Impatient, cranky, irritable, or resistive to help ____
Depression, sadness, or crying spells ____
Abnormal happiness ____
Sleep problems (too much or too little) ____
Nervous or worrying ____
Restlessness, rummaging or pacing ____
Loss of interest in usual activities ____
Paranoia or false beliefs ____
Hallucinations (false visions or voices) ____
Impulsive or embarrassing behavior ____
Physical aggression ____
Changes in appetite, weight, or eating habits _____
Hoarding ____

Has anyone on the patient's side of the family had problems with memory disorders, senility, or Alzheimer's disease? If so, who? Yes No _____

_____

Please complete the following in regards to the patient's activities of daily living.

Task	Help Needed	Details: Type of help needed
Using the telephone	Y / N	
Managing their medicines (like taking medicines on time)	Y / N	
Preparing meals	Y / N	
Managing money (like keeping track of expenses or paying bills)	Y / N	
Doing housework (such as doing the laundry)	Y / N	
Shopping for personal items like toiletries or medicines	Y / N	
Shopping for groceries	Y / N	
Driving	Y / N	
Feeding self	Y / N	
Getting from bed to chair	Y / N	
Getting to the toilet	Y / N	
Getting dressed	Y / N	
Bathing or showering	Y / N	
Walking across the room (includes using cane or walker)	Y / N	
Climbing a flight of stairs	Y / N	
Getting to places beyond walking distance (e.g. by bus, taxi, or car)	Y / N	

If the patient has not had brain imaging done, we may recommend it as part of their evaluation. Please complete the following:

MRI Safety Screening Sheet

The following items may be hazardous or may interfere with the MR examination by producing an artifact.

Please answer yes or no to the following:

Yes No Cardiac Pacemaker, or implanted Cardioverter/Defibrillator (ICD)

Yes No Internal electrodes, wires, retained pacemaker leads

Yes No Brain Aneurysm clip(s) or Aneurysm surgery

Yes No Shunt, Spinal, Intraventricular or Intracranial pressure monitor

Yes No Electronic implant or device. Neurostimulator, Spinal Cord stimulator, Bone fusion stimulator

Yes No Magnetically-activated implant or device

*If Yes, Please List:_____

Yes No Insulin or drug infusion pump, device

Yes No Medication or nicotine patch

Yes No Epidural catheter, Swanz-Ganz catheter, Groshong or Vascular access port

Yes No Intravascular Coil, Filter or Stent

*If Yes, Please List:_____

Yes No Any type of Prosthesis or Implant (eye, ear, heart valve, penile, artificial limb, etc)

Yes No Hearing aid (remove before entering MRI scan room)

Yes No Cochlear implant, Stapes implant, ear or otologic implant

Yes No Tissue expander (e.g. breast) or wire mesh implants

Yes No Joint replacement (hip, knee, etc)

Yes No Dentures or removable dental work

Yes No Bone/joint pins, screws, nail, wire, plate, etc

Yes No Diaphragm or IUD

Yes No Body piercing jewelry (remove before entering MRI scan room)

Yes No Permanent makeup or tattoo

*If Yes, Please List:_____

Yes No Do you have seizures, asthma, or allergic respiratory disease?

Yes No Drug or medication allergies? Please List:_____

Yes No Have you had an allergic reaction to contrast media or dye used for MRI?

Yes No Are you pregnant, suspect pregnancy or breast feeding?

Yes No Breathing problem, motion disorder or claustrophobia?

What is your goal for this evaluation?

_____

_____

_____

Questions for the Caregiver or Loved One:

Do you belong to a support group? Yes No

Do you have someone who can give you some relief if you need to go to the doctor, hair dresser, or out to see friends? Yes No

Who	Relationship	How Often	How Long

_____

_____

What was/is your occupation?_____

Do you feel you need:

Help with making a diagnosis? Yes No

Help with managing patient's behavior? Yes No

Help with handling your own feelings? Yes No

Help in other areas? (Please comment) Yes No

_____

_____

_____

Would you be interested the following services for the patient?

Participation in research projects/drug studies? Yes No

Medication review by a pharmacist? Yes No

Assessment of independent living skills? Yes No

Independent driving evaluation? Yes No

Fall risk assessment Yes No

Information about community resources? Yes No

Family therapy/counseling Yes No

Insurance Information:

Please complete all applicable information. This information is necessary to verify your coverage. Some information may be on the back of your card.

Name of patient's primary insurance: _____
Subscriber Name: _____
Policy number: _____ Group Number: _____
Effective Date: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone Number: _____

Is the Primary Insurance an HMO or PPO? Yes No
If so, does the patient need a referral to be seen by a specialist? Yes No

Name of patient's secondary insurance: _____
Subscriber Name: _____
Policy number: _____ Group Number: _____
Effective Date: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone Number: _____

Is the Secondary Insurance an HMO or PPO? Yes No
If so, does the patient need a referral to be seen by a specialist? Yes No

Pharmacy

Local Pharmacy Name: _____

Address: _____

Telephone Number: (_____)____-_____

Mail Order Pharmacy Name: _____

Telephone Number: (_____)____-_____ ID# _____

Remarks: Please use this space to provide any other information you think might be helpful in evaluating the patient's memory problem.

_____
_____
_____
_____
_____
_____

If you have any questions about completing this form, please call 813-974-4355 and speak with a Client Services Representative.

Thank you

Please complete the next portion, which is required by the Centers for Medicare & Medicaid Services (CMS) under the Meaningful Use Stage 1 requirements. Thank you.

As a result of the American Recovery and Reinvestment Act, the USF Physicians Group is required to collect patient data regarding race and ethnicity as part of information provided to the Centers for Medicare & Medicaid Services (CMS) under the Meaningful Use Stage 1 requirements. This information is required for all patients.

Would you please take a few extra moments to complete the information below. We very much appreciate your assistance in helping us collect this information.

Race (Select One)

___American Indian/Alaska Native
___Asian
___ Black
___Native Hawaiian/Other Pacific Islander
___ White
___ Declined
___ Unknown

Ethnicity (Select One)

___ Hispanic or Latino or Spanish Origin
___ Not Hispanic or Latino or Spanish Origin
___Unknown
___ Declined

Please note that you have the option of indicating "declined" above.

Language_____

Other required data to offer better service to you:

Preferred Method to Notify You of Upcoming Appointment (Select ***One*** Method Only As Your Preferred Contact)

_____Name of Person to Confirm Appt With:_____

_____Cell Phone Number _____

_____Home Phone Number_____

_____E-Mail – E-Mail Address_____

_____Text Message – Phone Number to Text_____

_____Do Not Call Me

_____No Response

DATE ENTERED:_____BY:_____(Initials)