POINT OF ENTRY RESPIRATORY SCREEN - OT/PT/ST USE

NAME: _____ **DATE:** _____ **TIME:** _____

TB/FLU SCREEN

Have you experienced any of the following in the last 10 days?

Fever greater than 100.4?	YES	NO
Cough?	YES	NO
Cough greater than 3 weeks?	YES	NO
Cough with blood produced?	YES	NO
Shortness of breath/difficulty breathing?	YES	NO
Sore throat?	YES	NO
Night sweats?	YES	NO
Unexplained weight loss?	YES	NO
Fatigue?	YES	NO

Do you have a history of TB or a positive TB skin test?	YES	NO
Have you had close contact with a person who has TB?	YES	NO

Have you:

Had contact with domestic poultry?	YES	NO
Traveled outside the US in the past 2 weeks?	YES	NO

If yes, name of the country: _____

Have you:

Had close contact with any person who has Avian Flu?	YES	NO
Had close contact with any person having an influenza-like illness?	YES	NO
Had occupational exposure to anyone having an influenza-like illness?	YES	NO

Do you have a known history of allergy to latex products?	YES	NO

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PATIENT IDENTIFICATION

POINT OF ENTRY RESPIRATORY SCREEN - OT/PT/ST USE

Patient Name:	DOB:	Therapist Update
Referring Physician:	Height: Weight:	(Initial and Date)

MEDICAL HISTORY

Diagnosis	Details/Explanation	
☐ Heart Problem:		
☐ High Blood Pressure:		
☐ Sinus/Cough/Asthma:		
☐ Lungs / TB / Bronchitis:		
☐ Hepatitis/Liver Disease:		
☐ Stomach/Digestive Problem:		
☐ Kidney / Bladder Problem		
☐ Stroke/Seizures/Epilepsy:		
☐ Cancer:		
☐ Diabetes:		
Do you check your own blood sugar? Y N How often:		
☐ Physical/Mental Abuse:		
☐ Learning Disabilities:		
☐ Emotional Problems:		
☐ Sickle Cell Anemia/Blood Disorders:		
☐ Other:		
☐ Other:		

MEDICATIONS

Please list all medications you are currently taking, including over the counter and supplements:

PREVIOUS SURGERIES

Surgery/Year

ALLERGIES

☐ None ☐ Medications ☐ Food ☐ Dye ☐ Latex ☐ Silver ☐ Other

Please List and Describe Reactions:

Have you been in the Emergency Room in the last 3 days? ☐ Yes ☐ No

Have you been in the hospital in the past 6 months? Please give dates and hospital:

Female Patients Only: Is it possible that you could be pregnant? ☐ Yes ☐ No

Date of last menstrual period:

Patient Signature: Date:

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MEDICAL HISTORY SUMMARY SHEET

PT

Patient Identification

What name do you prefer to be called?

SOCIAL SCREENS

Are you currently receiving any home health treatments? ☐ Yes ☐ No

Language Barrier? ☐ Yes ☐ No

Are you fluent in reading and writing English? ☐ Yes ☐ No

How would you rate your level of comfort with medical terminology?

☐ Very Comfortable ☐ Somewhat Comfortable ☐ Somewhat Uncomfortable ☐ Uncomfortable

How do you learn best? ☐ Discussion ☐ Demonstration ☐ Illustration

Habits: ☐ Non smoker ☐ Smoke? Packs per day ☐ Drugs? Explain:_____

☐ Alcohol? Amt: Explain:_____ ☐ Sleep: ☐ No problems ☐ Difficulty

Do you have dependable transportation to and from the clinic? ☐ Yes ☐ No

Would you like information about transportation services? ☐ Yes ☐ No

Would you like a social worker to contact you regarding financial difficulties? ☐ Yes ☐ No

SAFETY SCREENING

Do you feel safe at home? (SW referral) ☐ Yes ☐ No

Do you have intent to harm yourself or others? ☐ Yes ☐ No

Do you require help to take care of your daily needs? (OT referral) ☐ Yes ☐ No

Do you cough or choke while swallowing foods or liquids? (ST referral) ☐ Yes ☐ No

Do you feel like you have poor balance? (PT referral) ☐ Yes ☐ No

Do you feel unsteady when you walk? (PT referral) ☐ Yes ☐ No

Have you had any recent falls? ☐ Yes ☐ No If so, how many?

Explain:

NUTRITIONAL SCREENING

Are you on a special diet? ☐ Yes ☐ No

Explain:

How many meals do you eat per day?

Would you like teaching on diabetes? ☐ Yes ☐ No

Have you experienced unintentional weight loss of greater than 5 lbs in the last 30 days? ☐ Yes ☐ No

Have you experienced low food intake for more than 3 days? ☐ Yes ☐ No

Have you had nausea/vomiting/diarrhea for more than 3 days? ☐ Yes ☐ No

Do you have a feeding tube? ☐ Yes ☐ No

Do you have a non healing wound? ☐ Yes ☐ No

Patient Signature: Date:

Notes:

Therapist Signature: Date:

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SOCIAL/SAFETY SCREENING FORM

PT

Patient Identification

PATIENT CONTACT INFORMATION

PLEASE WRITE INFORMATION COMPLETELY AND LEGIBLY

Demographics

Name: _____

Date of Birth: _____

Social Security #: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Email Address: _____

Marital Status: _____

If pregnant, date of last Menstrual Period: ____/____/____

Employment

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Occupation: _____

Person who carries the insurance ☐ Same as patient

Name: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Social Security #: _____

Relationship: _____

Name of Employer

Address: _____

City/State/Zip: _____

Phone: _____

Occupation: _____

Next of Kin (spouse; parent if under 18)
☐ **Same person who carries insurance.**

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Work Phone: _____

Relationship: _____

If Spouse: _____

Person to Notify in Case of Emergency (if different)
☐ Same

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Relationship: _____

Other Guarantor (please list other parent if patient is under 18)

Name: _____

Social Security #: _____

Relationship: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Other Guarantor Employer

Address: _____

Phone: _____

Occupation: _____

Phone: _____

Occupation: _____

Are you currently participating in a research study? ☐ Yes ☐ No

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PATIENT IDENTIFICATION

PATIENT CONTACT INFORMATION

PT

Please answer the following questions:

Do you have or do you have any reason to believe you have a latex allergy? ☐ Yes ☐ No

Are you a member of H2U/Senior Friends? ☐ Yes ☐ No

Would you like information on becoming a member of H2U/Senior Friends? ☐ Yes ☐ No

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For Office Use Only:

Copay Amount Due: $ _____ . _____

Copay Amount Received: $ _____ . _____

Copay Received By: _____

Date Copay was Received: ____/____/____

Reason Copayment was not collected: _____

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LATEX, H2U, CO-PAY INFO

Patient Identification

Outpatient Therapy Services
(817) 255 1672

Attendance Policy

In order to provide effective treatment, regular attendance to therapy sessions is expected. If you are unable to attend a therapy session please call our office at **817-255-1672** twenty four hours prior to your scheduled therapy time. We will be happy to reschedule you for a more convenient time. Also, in order to provide the proper amount of time for you and other individuals we see, please arrive for your therapy session at the appointed time. Late arrival may forfeit your scheduled session for that day. It is our policy that after 3 consecutive no-shows or consistent late arrivals therapy will be canceled.
Thank you for choosing North Hills Hospital Outpatient Therapy. We look forward to serving you.

Sincerely,
Outpatient Therapy Staff

I have read the above policy and have received a copy of this form.

Patient/Guardian Signature _____ Date _____

Politica de Asistencia

Para lograr proporcionar un tratamiento efectivo durante sus terapias, es necesario que llegue a tiempo. Si usted no puede asistir a una sesión de terapia, por favor llame nuestra oficina a **817-255-1672** veinte cuatro horas de anticipación. Nuestro equipo de trabajo se complacerá en otorgarle una cita y horario a su conveniencia. Par poder suministrar un tratamiento efectivo para usted y otros clientes, es muy importante que usted asista a sus citas en el tiempo designado. Si usted llega retrasado a su cita, existe la posibilidad de perder su sesión por ese dia. Nuestra política de asistencia establece la posibilidad de cancelación de citas, si usted no se reporta 3 veces consecutivamente o llega retrasado consistentemente.

Gracias por elegir nuestro North Hills Hospital Outpatient Terapias. Anticipamos poder servirle con sus necesidades de rehabilitación.

Atentamente,
Outpatient Therapy Staff

He leído la politica antes mencionada y he recibido una copia de esta forma.

Firma del Paciente / Guarda _____ Fecha _____

Therapy Department Rights and Responsibilities

Welcome to North Hills Hospital Outpatient Therapy Department, We are glad to have you as a new patient, and we will do our best to serve your therapy needs. Our goal is to provide the highest possible patient care to each and every patient. In order to meet this goal, we will make the following commitments to you:

The Therapy staff will treat you promptly on your arrival, and treat you at your scheduled appointment time.
We will be considerate and compassionate. We will try to meet your therapy goals, as directed by your physician.
We will schedule your appointments in advance, within our scheduling confines, and will try to make those appointments as convenient as possible for you.

In order to provide a quality service to all of our patients, we make the following requests

If you are unable to make your scheduled appointment, please call us at **817-255-1672** as soon as possible.
Please call if you know you will be more than **10** minutes late and we will do our best to accommodate you.
If you are more than **15** minutes late for your appointment, without calling, your appointment will be forfeited.
If you miss **2** appointments without calling to cancel or reschedule, any future appointments your have scheduled will be canceled.

What you can expect:
On your first visit you will be asked to provide a prescription for therapy signed by your physician. Please be advised that we are obligated to treat you for the reason that you were referred here and cannot provide any treatment not authorized by your physician, prescribe any medication, or offer any diagnosis. Prescriptions are valid for only 30 days from the date they were issued. We cannot treat you beyond the duration specified by the physician. If your physician wishes to extend your therapy beyond the scope of the original prescription, it will be necessary for him/her to provide a new prescription. We will forward progress notes to your physician upon evaluation, discharge, periodically during treatment, and as requested.

Depending on your insurance, you may have some financial obligations for your treatment such as a co-payment per visit or percentage of the total cost, You may decide to pay per visit, per week, or at the end of your treatment. **Your financial responsibility is: _____ % / $ per Visit.**

Prior to beginning therapy, your therapist will perform an initial evaluation to identify your physical needs. Based on this evaluation, the therapist will develop specific therapy goals and a plan to help you achieve those goals with the aid of a licensed therapy assistant. Periodically, the therapist will re-evaluate your condition to determine your progress.

In order to receive the maximum benefits from therapy, we recommend you wear comfortable clothing and shoes, follow your home program, and maintain as close as possible the schedule of appointments recommend by you physician and therapist. If you have any additional questions, please feel free to ask your therapist, or any member of our staff.

Your Name: _____ Date: _____

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THERAPY DEPARTMENT RIGHTS AND RESPONSIBILITIES

* P T *

Patient Identification