Indiana University Health

RADIATION ONCOLOGY

PATIENT HISTORY/NURSING ASSESSMENT

DATE_____

NAME_____**AGE**_____**SEX**_____

DIAGNOSIS_____

Referred by Doctor_____ **Family Doctor**_____

Are you pregnant? _____ **Yes** _____**No** **Advanced directive addressed:** _____**Yes** _____**No**

Where was blood work done _____

Allergies _____

CHRONIC ILLNESSES: (examples: diabetes, high blood pressure, asthma, emphysema, heart disease, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PREVIOUS SURGERIES:

Operation	Surgeon	Where Performed	Date
1.			
2.			
3.			

PREVIOUS RADIATION THERAPY:

Area Treated	Radiation Oncologist	Where Performed	Date
1.			
2.			
3.			

PREVIOUS CHEMOTHERAPY:

Medical Oncologist	Date(s)
1.	
2.	

FAMILY HISTORY OF ANY OF THE FOLLOWING:

	Yes	No	If yes, explain
Cancer			
Diabetes			
High Blood Pressure			
Heart Disease			
Lung Disease			
Inherited Disorder			
Other			

SOCIAL HISTORY:

Occupation:_____

Chemical or other environmental exposures:_____

Cigaretts:_____ **packs per day**_____ **Years smokes**_____

Alcohol:_____ **drinks per day** _____

Recreational drugs:_____ **yes** _____ **no**

REVIEW OF SYSTEMS: (CIRCLE ALL THAT APPLY)

GENERAL INFORMATION:

- Recent weight change
- Loss of appetitie
- (Persistent) fevers
- Night Sweats
- Enlarged lymph nodes
- Skin sores/burns/itching

NEUROLOGICAL:

- Headaches
- Dizziness/blackouts
- Seizures
- Numbness or tingling
- Weakness or paralysis
- Visual problems
- Hearing problems

GASTRONTESTINAL:

- Abdominal or pelvic pain
- Nausea, vomiting
- Vomiting of blood
- Diarrhea
- Constipation
- Recent bowel changes
- Rectal bleeding
- History of diverticulitis or colitis
- Yellow jaundice

MEN ONLY:

- Prostate problems
- Penile discharge
- Swollen testicle

WOMEN ONLY :

- Vaginal Discharge
- Date of last menstrual period_____
- Method of birth control, if any_____

CHEST:

- Pain
- Shortness of breath
- Cough
- Coughing up blood
- Pacemaker

MOUTH/THROAT:

- Pain or soreness
- Non-healing lesions
- Shifting teeth
- Change in fit of dentures
- Change in voice
- Trouble swallowing
- Neck Mass
- Ear pain

GENITOURINARY:

- Urinary frequency
- Urinating ≥ 2 times during the night
- Urinary burning
- Blood in urine

MUSCULOSKELETAL:

- Back pain
- Bone pain
- Swelling of an extremity

BREAST:

- Breast lump or mass
- Breast pain
- Nipple change or discharge

_____ _____ _____

Patient's Signature **Nurse's Signature** **Staff Physician Signature**

Indiana University Health

Department of Radiation Oncology

Assessment of Nutritional Status/Need for Nutrition Intervention

Do you have a poor appetite leading to decreased food intake?	Y	N
Have you lost 10 or more pounds of weight recently without wanting to?	Y	N
Do you have mouth, chewing, or swallowing problems that make it difficult to eat?	Y	N
Are experiencing:	Y	N
Taste Changes that make you not want to eat?	Y	N
Diarrhea/Constipation?	Y	N
Nausea/Vomiting?	Y	N
Do you have or will you be getting a feeding tube?	Y	N
Are you, or will you be receiving Radiation Therapy to the neck, throat, or mouth area?	Y	N

For Nursing Only:

If patient answers yes to any of the above questions, refer to the Dietitian for consult per nurse discretion**

**** Add patient's name to Dietitian Referral List at Nurse's station.**

_____ Patient referred to dietitian

_____ Patient **NOT** referred to dietitian due to _____

_____ Patient given verbal/written dietary instructions from RN

RN Signature_____

Date: _____

Dietitian: Beth Kirsch, RD

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LL 1/25/11

Pager: 317-312-5592

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Indiana University Health

PATIENT'S MEDICATION LIST (Page 1)

1. MEDICATION ALLERGIES

Medication Name	Type of Reaction

☐ Inpatient ☐ Outpatient

2. MEDICATION LIST

Date of Entry	Medication	Dose	How Often	Check If Discontinued

Indiana University Health

FAMILY AND FRIEND COMMUNICATION LIST

Indiana University Health is committed to ensuring the privacy and security of patient health information. Reasonable steps will be taken to give you, as our patient, an opportunity to agree or object to the release of specific medical information to family members and close personal friends.

I permit Indiana University Health to communicate with family and friends, as identified below, the following information about my treatment and health care.

__ Any and all information
__ Information necessary to schedule, confirm, cancel or reschedule appointments
__ Information about test results
__ Information about prescriptions
__ Information about my bills or account
__ I grant permission to this individual to bring my child to his or her appointment

I understand this permission is valid until revoked by me. I understand Indiana University Health will not release to family or friends any information about HIV, sexually transmitted diseases, pregnancy tests, contraceptive counseling, psychotherapy notes, or drug and alcohol treatment. This information will be released only to the patient and to any public health agency to which Indiana University Health is legally bound to report such information.

I would like my code word to be _____.

Authorized Caller	Phone Number /Relationship		Date

Patient Signature	Patient's Printed Name	Date

Witness Signature	Witness' Printed Name	Date

Review, Initial, and Date at Follow-up Visit: _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

Indiana University Health

PATIENT E-MAIL USAGE CONSENT

(CONSENT REQUIRED FOR PROVIDER/PATIENT E-MAIL COMMUNICATION)

As a patient, I find it beneficial to communicate with my healthcare provider *(specify name below)* _____ via electronic mail (e-mail). E-mail can be a valid, simple, convenient and inexpensive mechanism for communication and can be an aid in the healthcare delivery process.

Types of Permitted E-mail Transmissions: The types of information that can be communicated via e-mail with the provider include, but are not limited to, prescription refills, patient referrals, appointment scheduling requests, billing/insurance questions/answers, and patient education. If I am not sure if the issue I wish to discuss should be included in an e-mail to the provider, I will call the provider's office to schedule an appointment.

Fees: Fees may be assessed for any communications or consultations with the provider via e-mail; however, no fee shall be assessed for questions involving general information such as clinic hours, location of clinic, appointment scheduling requests, and billing/insurance questions/answers.
Provider to list applicable fees that may be assessed for on-line consultation: _____

Alternate Forms of Communication: I understand that I may also communicate with the provider via telephone or during a scheduled appointment and that the e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive medical information.

Emergency Situations: E-mail should never be used for emergency situations or urgent problems. In the event of an emergency, I will call 911 or go to an emergency room, urgent care or immediate care facility.

Risks of Using E-mail to Communicate With My Provider: Transmitting patient information by e-mail has a number of risks that I will consider before using e-mail to communicate with the provider. These include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by unintended recipients.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail is easier to falsify than handwritten or signed documents.
- Back-up copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mails can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

Security Measures Taken by IU Health: IU Health uses the following security measures among others to ensure the security of protected health information.

- Patient-identifiable information is never forwarded to a third party except for treatment, payment or healthcare operations purposes, without the patient's express permission.
- Patient's e-mail addresses are never used for marketing purposes without the patient's permission.
- Professional e-mail accounts are not shared with patient's family members.
- E-mails are backed-up and archived on a regular basis.
- E-mail recipient addresses are verified prior to sending the message with a confidential indicator attached for the recipient.

Hold Harmless: I agree to indemnify and hold harmless the provider, his or her medical practice, IU Health, and its trustees, officers, directors, employees, agents, information providers, suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney fees, relating to or arising from any information loss due to technical failure, my use of the Internet to communicate with the provider, the use of the provider's website, any arrangements I make based on information obtained at the site, any products or services obtained through the site, and any breach by me of these restrictions and conditions. The provider does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the provider's website or server that makes such site available is free of viruses or other harmful components.

Forwarding E-mails: I understand there may be times in which the provider must forward the information I have provided via e-mail to a third party for treatment, billing or payment purposes. I expressly provide my consent to allow the provider to forward these e-mails to a third party under these conditions and evidence my consent by placing my initials here: _____ ***(Initial if you agree.)***

Termination of the E-mail Relationship: I have the right to revoke this consent, in writing, at any time by presenting the written revocation to my healthcare provider. The provider shall have the right to immediately terminate the e-mail relationship with me if he or she determines, in his or her sole discretion, that I have violated the terms and conditions set forth in the Agreement or have engaged in conduct which the provider determines to be unacceptable.

Patient Acknowledgement and Agreement: I hereby consent to the use of e-mail as a means of communication between a IU Health Provider and me. I have discussed this form with the provider, understand the inherent limitations related to electronic communications, understand the limits of e-mail transactions, hold harmless IU Health for loss of information due to technical failures and consent to these conditions and terms.

Patient Name *(printed)*: _____ E-mail Address: _____

Patient/Legal Representative Signature: _____ Date: _____