**Baptist**
**Hospitals of Southeast Texas**
**Regional Cancer Network**
*Performing Sacred Work Every Day*

***Board-Certified Medical Oncologists & Hematologists***
Harry Smith, MD • Tahir Naqvi, MD, MBA •Sohail Akbani, MD

***Board-Certified Radiation Oncologists***
Danny C. Chow, MD • Ernest C. Hymel, MD, PhD, MBA •Chisaroka Echendu, MD.PhD

Name:_____

Your appointment has been schedule with Dr. _____

Day/Date:_____

Arrival Time:_____ Appointment Time:_____

In addition to the completed new patient packet, please bring the following items to your appointment:

- Photo ID/Driver's License
- Insurance Card (s)
- All medications that you are currently taking in the prescription bottles
- Advance Directive and or Medical Power of Attorney, if you have them
- All images, imaging discs and test reports that you may have

If you should have any questions, or if you need to reschedule your appointment, please contact the clinic as soon as possible.

We look forward to meeting you,

**Baptist Regional Cancer Network**
*Patient Intake Coordinators*

**Julie & Ben Rogers Cancer Institute**
Office: 409.212.5922 Fax: 409.212.5943
3555 Stagg Dr., Beaumont, TX 77701

**Altus Cancer Center**
Office: 409.981.5510 Fax: 409.981.5511
310 N 11th St., Beaumont, TX 77702

**Cancer Center of Southeast Texas**
Office: 409.729.8088 Fax: 409.729.8089
8333 9th Ave., Suite G, Port Arthur, Texas 77642

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To Our Patients and Families,

On behalf of our Partners in Caring – our staff, volunteers and medical staff, we welcome you to the oncology and hematology departments of the Baptist Hospital Regional Cancer Network.

As a healthcare organization, we strive to fulfill our mission of providing quality healthcare and "Sacred Work" in a Christian environment. With the latest in technology, board certified physicians and oncology certified nurses, your healthcare is our highest priority.

Commission on Cancer® ACCREDITED PROGRAM
A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

You are receiving your care from an American College of Surgeons Commission on Cancer® (CoC) Accredited Program. Our cancer program has received this distinct recognition for our voluntary commitment to providing the highest quality, patient centered care. CoC accreditation ensure that key elements of superior cancer care are provided to each person treated here – quality cancer care focused on you.

The American College of Surgeons National Accreditation program for Breast Centers (ANPBC) has also fully accredited out breast cancer program. This accreditation is based on our commitment to providing the highest quality evaluation and management of patients with breast disease.

NAPBC® NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS | A QUALITY PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS

During the course of your treatment at Baptist Hospital and our facilities, you will encounter many different disciplines of clinical professionals each staff member is dedicated to always providing excellent care to meet your expectations. Please do not hesitate to ask questions during your stay to ensure we are giving you all the education necessary to meet your goals.

For over 60 years, Baptist Hospitals of Southeast Texas has been providing exceptional care and "Sacred Work" to our community, and it is our privilege to be of service to you and your family. From offering quality cancer services to implementation of the latest n innovative diagnostics, we are creating survivors in Southeast Texas, one patients at a time.


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It is our sincerest goal to provide you with the highest quality care, and to help support you as you face this difficult challenge.

An important component of caring for you is to assess you, not only physically, but to also care for your mental well-being.

In order for us to assist you with your overall wellness, we would like for you to answer a few questions.

Please take the time to complete the enclosed paperwork, and your healthcare provider and nurse will review it with you during your visit.

It is a privilege to care for you; thank you for entrusting us with your care.

Baptist Regional Cancer Network.

# BAPTIST HOSPITALS OF SOUTHEAST TEXAS
# AUTHORIZATION FOR THE USE AND DISCLOSURE OF PHI

1. I, _____, authorize Baptist Hospitals of Southeast Texas to:
   ❒ use (obtain) or ❒ disclose the following protected health information from the record(s) of:
   Name: _____ DOB: _____ SS#: _____
   Telephone Number: _____ Date of Service: _____
   Address (city/state/zip): _____

2. I understand that copies of the protected health information will be released to: ❒ Patient ❒ Hospital
   ❒ Insurance Company ❒ Attorney ❒ Other: _____

   ❒ Picked up — Name of recipient: _____
   Name of company: _____
   ❒ Sent to — Address: _____
   City, state, zip code: _____
   Telephone number: _____
   ❒ Faxed to — Facsimile number: _____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), treatment for history of drugs or alcohol abuse, or mental or behavioral health psychiatric care.

4. The information to be used or disclosed:
   ❒ Complete medical record ❒ Complete medical record excluding: _____
   ❒ Face Sheet ❒ History and Physical ❒ Discharge Summary ❒ ER Record
   ❒ Consultation Report ❒ Operative Report ❒ Progress Notes
   ❒ Test Results: (Specify): _____
   ❒ Other: _____

5. I request that my information be provided in the following format:
   ❒ Hardcopy (paper record) ❒ Electronic Media (PDF format)

6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal or Texas privacy regulations, the information described above may be redisclosed and no longer protected by Federal and/or Texas privacy regulations.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that Baptist Hospitals of Southeast Texas may not condition treatment on my completion of this authorization form.

8. I understand this authorization will expire in six months on (check and complete on):
   ❒ Date: ____/____/20__, OR
   ❒ On the happening of the following event that relates to me or the purpose of use or disclosure:

   I also understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. You must write to Privacy Officer at the appropriate address reflected in the hospital's Notice of Privacy Practices.

   The purpose of the use and disclosure is: (not required if requestor is the patient) _____
   _____

_____ ____/____/_____ _____
Time Date Signature of Patient or Patient's Representative

_____ _____
Printed Name of Patient's Representative Relationship to Patient

_____Legal
Authority (supporting documentation required – copy of power of attorney,etc.)

Baptist Hospitals of Southeast Texas
Regional Cancer Network
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# Password Program

## *Allowing Access to Your Protected Health Information*

Baptist Regional Cancer Network has developed the Password Program to allow you, as the -patient, to have control and allow LIMITED access to Protected Health Information (PHI). The Password Program allows you, as the patient, to give a Password to family members and friends that will allow them LIMITED access to information about you as a patient. The Password Program DOES NOT permit or allow access to your medical records or other information about you that goes beyond general information as described in the Joint Notice of Privacy Practices. Information provided by the Health Care Team Member will be based on his/her judgment and limited by legal and privacy parameters, as applicable.

For the purpose of the Password Program, LIMITED information shall mean:

1. General Update on patient condition (i.e. good condition, improved, stable, etc.)
2. Current treatment plans in very general terms (i.e. patient is scheduled for procedure/test; patient tolerated procedure/test, etc.)
3. Discharge Planning in very general terms (i.e. Home Health; Hospice, etc.)

All other information related to you, as a patient, will not be provided by our Health Care Team Members except as otherwise noted in the Joint Notice on Privacy Practices.

Your rights as a patient regarding Protected Health Information are explained in the Joint Notice of Privacy Practices.

Signing and dating this authorization form is acknowledgment that you wish to participate in the Password Program.

1. I understand that I may revoke this authorization and participation in the Password Program at any time except to the extent that Baptist Regional Cancer Network has already acted on this authorization. I understand that I may revoke this authorization by completing and signing a revocation form stating my intent to revoke this authorization and returning the completed form to my Health Care Team Member.
2. Unless otherwise revoked, I understand that this authorization expires at discharge of my care from Baptist Regional Cancer Network.
3. I understand that Baptist Regional Cancer Network may not condition treatment depending on my decision to or not to initiate this authorization form.

Signature of Patient or Patient's Legal Representative: _____

Printed Name of Legal Representative (if any): _____

Representative's Authority to Act for Patients: _____

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# Publicity and Media Consent and Release Form

I, _____, hereby consent to allow Baptist Hospital of Southeast Texas Regional Cancer Network, its agents, representatives, employees, successors, or assign, to photograph, video tape, voice or data record me. I further grant to Baptist Hospital of Southeast Texas Regional Cancer Network and/or its nominees (including any legitimate publisher), the absolute right and permission to copyright, reproduce, broadcast, telecast and/or publish the photograph(s), film, videotape, recordings, endorsement or copy in which I may be included in whole or part, or composite form for utilization in diagnostics, documentation, treatment and/or teaching or demonstration purposes, or art purposes, trade, web site use, social media, advertising and all advertising media, or for any lawful reproduction purpose whatsoever without limit or reservation. I understand and agree this may include a limited amount of information regarding my medical condition and/or treatment at the Baptist Hospital of Southeast Texas Regional Cancer Network and affiliated entities. I further agree to release Baptist Hospital of Southeast Texas Regional Cancer Network, its agents, representatives, employees, successors, or assigns from any liability by virtue of any blurring, distortion, or use in composite form, that may occur or be produced in the taking and reproducing of said photograph(s), videotape, or recording, or in any processing tending toward the completion of the finished product. I agree to receive appointment notifications through an automated messaging service.

☐ I wish to receive newsletters, invitations, information and e-mails, etc.

☐ I **do not** wish to receive newsletters, invitations, information and e-mails, etc.

☐ Upon completion of treatment, I wish to have my picture posted on the "Heroes" Wall

☐ Upon completion of treatment, **I do not** wish to have my picture posted on the "Heroes" Wall

☐ I **do not** consent to an automated phone messaging system to leaving appointment notification on the phone number(s)that I have provided.

Signature: _____ Date: _____

Printed Name: _____

Address: _____

City: _____ State: TX Zip Code: _____

Phone Number: _____

Witness: _____

Date: _____

Reviewed/Revised: 6/29/19

Baptist Hospitals of Southeast Texas
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# Password Program
## *Allowing Access to Your Protected Health Information*

Date and Time Received: _____

We are required by law to maintain the privacy of your medical information. As discussed in detail in our Joint Notice of Privacy Practices, there are categories or situations in which we are permitted by law to use and disclose medical information about you. To help ensure that your Protected Health Information (PHI) stays confidential, we will not provide information over the phone or in person to anyone other than as described in the categories or situations noted in the Joint Notice of Privacy Practices.

We realize that this can place a difficult strain on family members and friends who wish to know how you are doing as a patient. To help with this situation we have developed a Password Program that will allow you, as the patient, to control and allow LIMITED access to your Protected Health Information.

## How Does the Program Work?

The Password Program allows you, as the patient, to give a Password to family members and friends that will allow them access to LIMITED information about you as a patient. When a family member or friend calls or visits Baptist Regional Cancer Network, they can provide the password to the Health Care Team Member helping them. Upon verification of the Password, that Health Care Team Member will be able to, using his/her judgment, provide LIMITED information about you to that family member or friend.

The Password Program does not permit or allow family members or friends to have access to your medical record or other personal or healthcare information.

**Control and distribution of the Password is the responsibility of the patient or his/her legal representative.**

For your convenience, patients at Baptist Regional Cancer Network, **will use the last four (4) numbers of their social security number as their PASSWORD.**

**Your Identification Number is:**

____ ____ ____ ____

**KEEP THIS FORM FOR YOUR PERSONAL RECORDS**

You may give your Password to anyone that you wish. To participate in the Password Program, please sign and complete the Password Authorization Form. This will become a part of your medical record. Your participation in this program is completely voluntary. You may revoke your participation in this program at anytime, by completing the Password Program Revocation Form and turning the signed form into a Health Care Team Member. Baptist Regional Cancer Network will not condition treatment depending on your participation or refusal to participate in the program. If you have any questions regarding the Password Program, please

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Regional Cancer Network
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## Password Program
### *Allowing Access to Your Protected Health Information*

contact a member of the Health Care Team. ***Thank you for choosing Baptist Regional Cancer Network to provide your care.***

**HISTORY OF PRESENT ILLNESS:**

What were your symptoms leading to diagnosis? _____

_____

_____

**Diagnostic Tests**

| Test/Study | Date Performed | Where performed? | Name of ordering physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Have you received any treatment for the above problem? YES** **NO** (Skip to the next section)

**Chemotherapy**

| Type of Chemotherapy | Dates of treatment | Where received? | Name of Medical Oncologist |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Radiation Therapy**

| Area of Body Treated | Dates of treatment | Where received? | Name of Radiation Oncologist |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**VITAL SIGNS: (**FOR NURSE USE ONLY**)**

Height: _____ Weight: _____ Blood Pressure: _____

Pulse: _____ Respirations: _____ Temperature: _____

O2 Saturation: _____% Fatigue: _____/10 Distress: _____/10

Pain: _____/10 Location of pain: _____

Description of Pain: _____ Frequency of Pain: _____

Time of Day Pain is worst: _____

**MEDICAL HISTORY – *all previous and existing medical problems (check all that apply)***

☐ Cancer (specify type):_____

| | |
|---|---|
| ☐ Glaucoma ☐ Right ☐ Left | ☐ Liver Cirrhosis |
| ☐ Cataracts ☐ Right ☐ Left | ☐ Hepatitis ☐ A ☐ B ☐ C |
| ☐ Headaches/Migraines | ☐ HIV |
| ☐ Diabetes ☐ On Insulin ☐ On Oral Medication ☐ Diet Controlled | ☐ Pancreatitis |
| ☐ Thyroid Disease ☐ Hyperthyroidism ☐ Hypothyroidism | ☐ Hypertension |
| ☐ Esophageal Reflux/GERD | ☐ High Cholesterol |
| ☐ Hiatal Hernia | ☐ Heart Disease |
| ☐ Stomach Ulcers | ☐ Coronary Artery Disease |
| ☐ Chron's Disease | ☐ Arrhythmia |
| ☐ Diverticulitis | ☐ Heart Attack/MI |
| ☐ Hemorrhoids | ☐ Pace Maker ☐ Defibrillator |
| ☐ Peripheral Vascular Disease | ☐ Arthritis |
| ☐ Blood Clots in Legs/ DVT | ☐ Rheumatoid Arthritis |
| ☐ Stroke/CVA/TIA | ☐ Osteoarthritis |
| ☐ COPD/Emphysema | ☐ Depression |
| ☐ Asthma | ☐ Anxiety |
| ☐ Bronchitis | ☐ Bipolar |
| ☐ Pneumonia | ☐ Schizophrenia |
| ☐ Tuberculosis/TB | ☐ Suicidal Thoughts Explain: _____ |
| ☐ Sleep Apnea | ☐ Implants Type/Location:_____ |
| ☐ Kidney/Renal Disease | ☐ Prosthesis Type/Location_____ |
| ☐ Kidney/Renal Failure ☐ Dialysis | ☐ Problems with Anesthesia Explain:_____ |
| ☐ Anemia | ☐ Other |
| ☐ Sickle Cell Disease | ☐ Other |
| ☐ Bleeding disorder | ☐ Other |
| ☐ Lupus/Scleroderma | ☐ Other |

**FOR Women only:**

Age at first menstruation: _____ Last menstrual period: ___/___/___ Age at Menopause: _____

If still menstruating: Have they been regular? ☐ Y ☐ N Number of days about the same? ☐ Y ☐ N

Age at first pregnancy: _____ Number of Pregnancies: _____ Number of living births: _____

Number of miscarriages/abortion/stillbirths: _____

Did you breast feed: ☐ Y ☐ N If yes, number of times: _____ For how long: _____

Have you had a hysterectomy? ☐ Y ☐ N Were your ovaries removed? ☐ Y ☐ N Date: __/___/____

Have you ever taken birth control pills? ☐ Y ☐ N If yes, how many years? _____

Have you ever taken Estrogen/Hormone Replacement Therapy? ☐ Y ☐ N

Date Started: _____/_____/_____ Date Stopped: _____/_____/_____

Date of last Mammogram: _____/_____/_____ Date of last PAP smear: _____/_____/_____

## SURGICAL/PROCEDURAL HISTORY

| Check as appropriate | Year | Surgery/Procedure | Check as appropriate | Year | Surgery/Procedure |
|---|---|---|---|---|---|
| | | Appendix Removed | | | Gallbladder Removed |
| | | Bronchoscopy | | | Hemorrhoid (s) Removed |
| | | Lung Biopsy | | | Hysterectomy |
| | | Back Surgery | | | Ovaries Removed ☐ One ☐ Both |
| | | Bladder Surgery | | | Knee Surgery ☐ R ☐ L |
| | | Breast Biopsy ☐ R ☐ L | | | Kidney/Renal Stent |
| | | Breast Surgery ☐ R ☐ L | | | Kidney Surgery |
| | | Mastectomy ☐ R ☐ L | | | Liver Resection |
| | | Segmental Mastectomy ☐ R ☐ L | | | Biopsy Site:_____ |
| | | Lumpectomy ☐ R ☐ L | | | Pancreas Surgery |
| | | Cataract Removal ☐ R ☐ L | | | Prostate Biopsy |
| | | Cardiac Stent | | | Prostate Surgery |
| | | Cardiac Bypass Surgery | | | TURP |
| | | Colonoscopy | | | Tonsils Removed |
| | | Upper GI Endoscopy (EGD) | | | Other:_____ |
| | | Colon/Rectal Surgery ☐ Colostomy ☐ Ileostomy | | | Other:_____ |
| | | Femoral Popliteal Bypass ☐ R ☐ L | | | Other:_____ |

## FAMILY HISTORY

### GENERAL FAMILY HISTORY – Check if yes

| | | | |
|---|---|---|---|
| Mother's side of Family | ☐ Heart Disease | ☐ Hypertension (high blood pressure | ☐ Diabetes |
| Fathers side of Family | ☐ Heart Disease | ☐ Hypertension (high blood pressure | ☐ Diabetes |

**SOCIAL HISTORY**

Your Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
With whom do you live? _____
Are you a primary caregiver? ☐ Yes ☐ No Who do you care for? _____
Do you receive Home Health? ☐ Yes ☐ No Agency? _____
Do you have home oxygen? ☐ Yes ☐ No _____L/minute
Do you have home equipment? ☐ Yes ☐ No Type: _____
Do you feel that you live in an environment safe from physical and mental abuse? ☐ Yes ☐ No
Within the past year, have you been hit, slapped, kicked, or otherwise hurt by anyone? ☐ Yes ☐ No
Do you know how to get help if you or someone you know were worried about domestic violence? ☐ Yes ☐ No
Employment:

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled

Date of retirement/disability: _____/_____/_____

If disabled are you enrolled in: ☐ SSI ☐ SSDI ☐ Pending ☐ Denied

**Health Exposures and Habits**

Last flu vaccine ___/___/___ Last Pneumonia Vaccine ___/___/___ Shingles Vaccine ___/___/___
Job related exposures (benzene, asbestos etc.): _____
Tobacco use: ☐ Yes ☐ No

☐ cigarettes ☐ cigars ☐ pipe ☐ chewing tobacco

☐ I smoke(d) _____ packs per day for the last _____ years

☐ I quit smoking (when or how long ago?) _____

☐ I am interested in Smoking/Tobacco Cessation ☐ Yes ☐ No

Alcohol use: Do you consume alcoholic beverages? ☐ Yes ☐ No

How often do you consume them? ☐ Every day ☐ Some days ☐ Socially

☐ I currently average _____ drinks/glasses of wine/day, _____cans/bottles beer/day

☐ I quit _____ years/months ago, after _____ years of drinking on the average _____drinks/glasses of wine/day, _____cans/bottles beer/day

**Advance Directives/Living Will**

Do you have an Advance Directive/Living Will? ☐ Yes ☐ No Medical Power of Attorney? ☐ Yes ☐ No
Do you have a Texas Department of Health out of Hospital DO NOT Resuscitate Order? ☐ Yes ☐ No

If yes to any of the above: ☐ Provided clinic with copy ☐ Asked family to bring a copy

Would you like more information on any of the above items (Living Will/Advance Directives)? ☐ Yes ☐ No

**REVIEW OF SYSTEMS** ** Please check any box that applies to you and give an explanation**

| **Body System** | **Details** | ****For Nurse Use ONLY**** |
|---|---|---|
| Constitutional<br>☐ Fever ☐ Chills ☐ Night Sweats<br>☐ Excess Fatigue ☐ Weight Loss | | |
| Eyes<br>☐ Visual Difficulties ☐ Double Vision | | |
| Ears, Nose, Mouth, Throat<br>☐ Hard of Hearing<br>☐ Sore Throat ☐ Sinus Drainage | | |
| Endocrine<br>☐ Diabetes ☐ Thyroid problems<br>☐ Hormone replacement<br>☐ Hot flashes ☐ Night sweats | | |
| Hematologic/Lymphatic<br>☐ Easy bruising ☐ Bleeding<br>☐ Enlarged/tender lymph nodes | | |
| Breasts<br>☐ Masses ☐ Nipple discharge ☐ Pain | | |
| Respiratory<br>☐ Short of breath on exertion<br>☐ Cough ☐ Bloody sputum | | |
| Cardiovascular<br>☐ Chest pain ☐ Palpitations<br>☐ Lightheadedness/dizziness | | |
| Gastrointestinal<br>☐ Nausea ☐ Vomiting ☐ Diarrhea<br>☐ Constipation ☐ Heartburn<br>☐ Bleeding from rectum<br>☐ Change in bowel habits | | |
| Urinary<br>☐ Blood in urine ☐ Incontinence<br>☐ Hesitancy ☐ Weak stream<br>☐ Bleeding or discharge | | |
| Musculoskeletal<br>☐ Joint pain ☐ Joint swelling/tenderness<br>☐ Use of cane/walker ☐ Limited range of motion | | |
| Skin<br>☐ Rash ☐ Open wounds ☐ Skin changes | | |
| Neurological<br>☐ Headache ☐ Weakness ☐ Numbness/tingling | | |
| Psychiatric<br>☐ Insomnia ☐ Depression ☐ Mood Swings<br>☐ Anxiety | | |

**Additional Information:** If there is anything else you would like us to know about yourself or your visit with us today please provide in the space below.

**Patient signature**

_____
Signature

_____
Printed Name

_____
Date/Time

**or Guardian/Surrogate Signature**
**(if you have a medical POA, please provide a copy)**

_____
Signature

_____
Printed Name

_____
Date/Time

**Please take this to the front desk when completed.**

Baptist Hospitals of Southeast Texas Regional Cancer Network
Performing Sacred Work Every Day

**1) Have you ever had cancer?**

☐ No ☐ Yes Cancer site_____Age at diagnosis _____

**2) Have any of these people had cancer? (consider Mom's side and / or Dad's side equally)**

**You**, Parent, Child, Grandparent, Sibling / Half Sibling, Grandchild, Niece / Nephew, Aunt / Uncle

☐ No (**STOP**, Do not answer anymore questions)
☐ Yes (please answer the following questions)

**3) Check all that apply in you or a family member....**

☐ Ovarian / fallopian / peritoneal cancer diagnosed at any age
☐ **Personal** breast cancer at any age
☐ Breast cancer diagnosed at or under the age of 49
☐ 2 cases of breast cancer on the same side of the family - with one of the diagnosis at or under 50
☐ Bilateral breast cancer diagnosed at any age
☐ **Personal** Uterine / endometrial cancer diagnosed at or under the age of 64
☐ Uterine / endometrial cancer diagnosed at or under the age of 50
☐ Colon cancer diagnosed at or under the age of 50
☐ **Personal** Colon cancer diagnosed at or under the age of 64
☐ 20 or more colon polyps
☐ Male breast cancer diagnosed at any age
☐ Ashkenazi Jewish ancestry (Central / Eastern European) with breast cancer diagnosed at any age
☐ Triple Negative breast cancer diagnosed at or under the age of 60
☐ 3 or more cases of cancer on the same side of the family (any combination of these) breast, ovarian, pancreatic, prostate
☐ Metastatic prostate cancer any age
☐ Pancreatic cancer at any age

List any other cancers not listed above: _____

**This questionnaire will be reviewed by a health care professional with Baptist Regional Cancer Network. If they feel you may meet criteria for genetic testing, you will be placed on the phone to speak with a Certified Genetic Counselor. There is no charge for this educational service to speak to a Certified Genetic Counselor regarding your personal and / or family history or cancer. Simply talking with the Certified Genetic Counselor does not commit you to genetic testing, but is an educational service. This Certified Genetic Counselor is not employed by Baptist Regional Cancer Network but is provided by a third party. Please indicate if you do or do not consent to sharing your information with the Certified Genetic Counselor.**

☐ **Yes, I do consent to my information being shared** ☐ **No, I do NOT consent with my information being shared**

Patient Signature:_____Today's Date: _____

Patient Label

## ALLERGIES AND HOME MEDICATIONS

**Drug Allergies** ☐ **None Known**

| Medication Name | **Describe the allergic reaction** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Other Allergies** ☐ Food _____

☐ Tape ☐ IV contrast ☐ Iodine ☐ Latex

☐ Other: _____

**Current Home Medications** ☐ **None**

**Pharmacy of Choice:** _____

*****Please bring all medications with you on your first visit with the physician******

Please list all current medications, vitamins and supplements you take below

| **Name of Medication** | **Dosage** | **Number of times taken per day** | **Approximate month/year it was started** | **Doctor who prescribed the Medication** |
|---|---|---|---|---|
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☐ More (if so, please list on the next page)



Patient Label

## Current Home Medications (Continued)

| Name of Medication | Dosage | Number of times taken per day | Approximate month/year it was started | Doctor who prescribed the Medication |
|---|---|---|---|---|
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Patient Label

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Please provide a list of all the physicians you see (including psychiatric care):

| Physician Name | Specialty |
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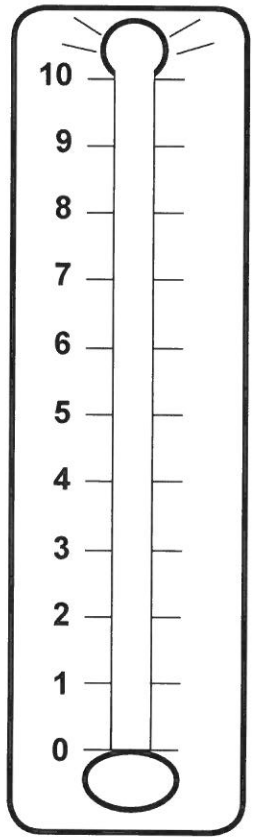
National Comprehensive Cancer Network®

# NCCN Distress Thermometer and Problem List for Patients

## NCCN DISTRESS THERMOMETER

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

**Extreme distress**




**No distress**

## PROBLEM LIST

**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 |

| | | Family Problems |
|---|---|---|
| ❑ | ❑ | Dealing with children |
| ❑ | ❑ | Dealing with partner |
| ❑ | ❑ | Ability to have children |
| ❑ | ❑ | Family health issues |

| | | Emotional Problems |
|---|---|---|
| ❑ | ❑ | Depression |
| ❑ | ❑ | Fears |
| ❑ | ❑ | Nervousness |
| ❑ | ❑ | Sadness |
| ❑ | ❑ | Worry |
| ❑ | ❑ | Loss of interest in usual activities |

| | | 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 |
| ❑ | ❑ | Substance abuse |
| ❑ | ❑ | Tingling in hands/feet |

**Other Problems:** _____

_____

# PATIENT HEALTH QUESTIONNAIRE–9
# (PHQ–9)

**PATIENT NAME:** _____ **DATE:** _____

**DATE OF BIRTH:** _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

| *(Use"✓" to indicate your answer)* | Not at all | Several Days | More than half the days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**FOR OFFICE CODING** 0 + ____ + ____ + ____

**= TOTAL SCORE:** ____

**If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ❒ | ❒ | ❒ | ❒ |



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Beaumont
(409)212–5000
CC084

BAPTIST HOSPITALS OF SOUTHEAST TEXAS

Patient Name: Patient Account:
MedRecNum:
Birth Date: Age: Sex:
Admit Date: Room/Bed: – HSV:
Attending Physician:
Primary Care Physician:
Referring Physician:

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Directions to Baptist Regional Cancer Network, Julie and Ben Rogers Campus:

I-10 from Vidor/Lumberton: Exit College Street/Highway 90, take a left under Interstate 10. Proceed down College Street and take a left at the second light. This is 8th Street. Proceed down 8th Street and take a left turn onto Stagg Drive. The Julie and Ben Rogers Campus of Baptist Regional Cancer Network is the last two story building on the left.

I-10 from Winnie: Exit College Street/Highway 90, take a right. Proceed down College Street and take a left at the second light. This is 8th Street. Proceed down 8th Street and take a left turn onto Stagg Drive. The Julie and Ben Rogers Campus of Baptist Regional Cancer Network is the last two story building on the left.

Hwy 69/287/Mid-County: Exit College Street/Highway 90, take a right. Proceed down College Street and take a left at the second light. This is 8th Street. Proceed down 8th Street and take a left turn onto Stagg Drive. The Julie and Ben Rogers Campus of Baptist Regional Cancer Network is the last two story building on the left.

**Should you get lost, please call 212-5922 and someone will be happy to assist you.**

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Directions to Baptist Regional Cancer Network, Altus Campus:

I-10 from Vidor/Lumberton: Exit 11th Street from I-10 (from Vidor) or. Continue on 11th Street heading toward College Street. The Altus campus is approximately 1.6 miles on the left, just across the street from St. Anne's Catholic School.

I-10 from Winnie: Exit College Street/Highway 90, take a right. Proceed down College Street and take a left at 11th Street; the first light. Proceed down 11th Street approximately one mile. The Altus Campus of Baptist Regional Cancer Network is on the right. If you get to Calder you have gone too far.

Hwy 69/287/Mid-County: Exit College Street/Highway 90, take a right. Proceed down College Street and take a left at 11th Street; the first light. Proceed down 11th Street approximately one mile. The Altus Campus of Baptist Regional Cancer Network is on the right. If you get to Calder you have gone too far.

**Should you get lost, please call 981-5510 and someone will be happy to assist you.**

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Directions to Baptist Regional Cancer Network, Cancer Center of Southeast Texas Campus:

From Orange/Bridge City: Highway 87/73. Exit Highway 69/96/287 North heading toward Beaumont. Exit Highway 365 and turn right onto Highway 365. Go past Central Mall. The second light just past Central Mall is 9th Avenue. Turn Right. The Center is located approximately 0.4 mile on the right. If you reach Turtle Creek Drive you have gone too far.

From Port Acres/Fannett: Take Highway 365 West, toward Central Mall. Go past Central Mall. The second light just past Central Mall is 9th Avenue. Turn Right. The Center is located approximately 0.4 mile on the right. If you reach Turtle Creek Drive you have gone too far.

From Port Neches/Groves: Take Highway 365 toward Central Mall. Turn Left on 9th Avenue. The Center is located approximately 0.4 mile on the right. If you reach Turtle Creek Drive you have gone too far.

**Should you get lost, please call 729-8088 and someone will be happy to assist you.**