

## WELCOME TO THE UPMC LIVER CANCER CENTER

### PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

You are scheduled to have an appointment at the UPMC Liver Cancer Center which is located in St. Margaret Hospital, Medical Arts Building, Suite 113. If parking in any UPMC garage, please remember to bring your parking ticket for validation to receive a discounted parking rate.

We will need the following items to prepare for your appointment:

- ❖ **Patient Assessment Form**: Please fill out and bring to your appointment the four page form that is enclosed in this packet. Please list ALL medication names, dosage, and how many times a day you take the medication; also include any over the counter and herbal medications you may take. Please list ALL physicians that take part in your care including address, phone number and fax number if available.
- ❖ **Release of Information Form**: Please fill out and bring this form with you to your appointment. The **only area** you need to fill in is your name, date of birth, social security number, and a signature.
- ❖ **Insurance Card(s)**: If your insurance requires you to have a referral, please obtain this prior to your appointment and have the doctor's office fax it to us at 412-692-2002.
- ❖ **CT scans/MRI/Ultrasounds (ONLY IF NECESSARY)**: Please obtain a copy of all scans and testing that you have had done from another hospital other than UPMC. You may carry these with you to your appointment.
- ❖ **Liver biopsy and pathology slides (ONLY IF NECESSARY)**: Please obtain a copy of your liver biopsy slides from any hospital other than UPMC. You may hand carry these slides with you to your appointment.

If you have any questions pertaining to your appointment or any of the information contained within, please call the Liver Cancer Center and your nurse coordinator or office staff will help in any way, 412-692-2001. Please remember that if your name, address, phone number, or insurance information changes during your course of treatment at the Liver Cancer Center, please notify our office.

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I authorize \_\_\_\_\_ to release information from the record of: \_\_\_\_\_  
Name of Facility/Person

\_\_\_\_\_ to \_\_\_\_\_  
Patient Name Birth Date SSN/MR#

\_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Name of Facility/Person Phone Fax

\_\_\_\_\_ Facility/Person Address

for the purpose of **(PROVIDE A DETAILED DESCRIPTION):** \_\_\_\_\_

**Parts 1 and 2 must be completed to properly identify the records to be released.**

**1. Type of records to be released and approximate date(s) of service (check all that apply):**

- Inpatient       Emergency Dept      Dates: \_\_\_\_\_
- Outpatient       Physician Office/Clinic

**I authorize the release of: (check all that apply)  Mental Health Information  Drug and Alcohol Information, contained in the records indicated above.**

**2. Specific information to be released (check all that apply):**

- Consults       Medical History & Physical Exam       Physician Orders
- Discharge Summary/Instructions       Medication Records       Progress Notes
- Laboratory Reports/Tests       Operative Report       Psychiatric/Psychological Eval
- Mammography Report       Pathology Report       Radiology Report
- Emergency Dept. Report       EKG Report(s)
- Other: \_\_\_\_\_

**HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.  Do not release**

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.**  
 If applicable, specify other expiration date/event here: \_\_\_\_\_

Date of Signature	Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & Alcohol treatment information without parental consent.)	Date of Signature		Signature of Parent, Legal Guardian or Authorized Representative* (complete below)
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Date of Signature	Witness/Staff Member Signature
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**\*Authorized Representative's relationship and authority to act on behalf of patient:** \_\_\_\_\_

**ORAL AUTHORIZATION (for persons physically unable to sign)  
 NOT Applicable To HIV Related Information or Drug & Alcohol Treatment Information**

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date	Witness #1	Date	Witness #2
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**Additional Patient Rights and Responsibilities**

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- UPMC cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- A verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations.
- I am entitled to a copy of this completed Authorization form.

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**Copy of authorization must be provided to patients when authorization is initiated by UPMC and for all Drug and Alcohol Treatment Patients.**

- Copy of authorization provided to patient
- Copy of authorization refused

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**Staff and Copy Service Use Only (Optional)**

Staff/Copy Service Signature: \_\_\_\_\_

- I.D. Obtained       Signature Checked       Other \_\_\_\_\_

Type of I.D.: \_\_\_\_\_

- Fee \$ \_\_\_\_\_       No Fee

Records Released By: \_\_\_\_\_

Date Released: \_\_\_\_\_

## PATIENT ASSESSMENT FORM FOR NEW PATIENTS

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female

Is today's visit for a second opinion? Yes  No

Reason for today's visit: \_\_\_\_\_

Self-Referral  PCP  Oncologist  Friend  Web Site

Internet  Other: \_\_\_\_\_

### HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING CONDITIONS?

Condition	Yes	NO	Condition	Yes	No
Mitral Valve Prolapse			Shortness of Breath		
Heart Disease			Cough		
High Blood Pressure			Asthma		
Chest Pain			Bronchitis		
Rheumatic Fever			Thyroid Disease		
An Abnormal Cardiogram			Diabetes		
Heart Attack			Low Blood Sugar		
Anemia			Recent Weight Gain/Loss		
Headaches			Loss of Urine		
Seizures/Convulsions			Bladder Disease		
Blurred Vision			Kidney Disease		
ringing in your ears			Kidney Stones		
Lightheadedness			Urinary Tract Infection		
Difficulty Sleeping			Stomach Pains		
Arthritis			Nausea and/or Vomiting		
Leg Cramps			Loss of Appetite		
Back Pain			Gallbladder Disease		
Phlebitis/Blood Clots			Change in Bowel Habits		
Numbness in hands or feet			Diarrhea/Constipation		
Skin Lesions			Colitis		
Poor Hearing			Ulcer Disease		
Easy Bruising			Yellow Jaundice		
Family history of Cancer			Hepatitis		

**DO YOU HAVE.....**

**DO YOU HAVE.....**

History of Smoking			History of Depression		
Number of packs per day:			History of Stress		
History of Alcohol			History of other Emotional Problems		
Number of drinks per day:			History of Anxiety		
History of Drug abuse					

Are you in any pain? Yes  No  Level 0-10 \_\_\_\_\_ (0 = no pain; 10 = extreme pain)

Has your appetite changed in the last three months? Yes  No

During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

Not at all  Very little  Some what  Quite a lot  Could not do physical activities

During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?

Not at all  Very little  Somewhat  Quite a lot  Could not do physical activities

Patient's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**MEDICATIONS-PLEASE PRINT NAMES OF MEDICATIONS AND DOSE:**

Medication	Dose	Time

**PLEASE LIST ALLEGIES TO MEDICATIONS:**

Medication	Side Effect

**PREVIOUS SURGERY INFORMATION:**

Type of Surgery	Date

**PREVIOUS MEDICAL HISTORY:**

Medical Condition	Date of Onset

**FAMILY MEDICAL HISTORY: (include all types of cancer)**

Medical Condition	Family Member

Patient's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**PATIENT/PHYSICIAN INFORMATION (YOU MUST FILL OUT COMPLETELY)**

**Referring Physician or Primary Care Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Please list any other Physicians you currently see:**

**Physician Name:** \_\_\_\_\_

**Address/Phone:** \_\_\_\_\_

\_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Address/Phone:** \_\_\_\_\_

\_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Address/Phone:** \_\_\_\_\_

\_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Address/Phone:** \_\_\_\_\_

\_\_\_\_\_

**University of Pittsburgh Medical Center (UPMC)**  
**Personal Representative Designation Form**

**Dear Patient:**

We understand that you wish to appoint a personal representative to act on your behalf in discussing and reviewing your health care information. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Note that, subject to the disclaimers in the following paragraph, this form may be used to document the following types of personal representative relationships: 1) making appointments for health care services; 2) discussions with health care providers about routine tests and treatments (do not require informed consent); and 3) access to medical records.

**Note that this form is not applicable and cannot be used for UPMC behavioral health patients or for any patient when major health care decisions are involved**, including, but not be limited to: 1) procedures/services that require informed consent (and withdrawal of consent if applicable); 2) admissions to and discharges from nursing homes or other long-term care facilities; 3) donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy; and, 4) continuation or withdrawal of life support. For major health care decisions, a formal power of attorney or living will is recommended.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

*This personal representative designation only applies to the following UPMC entity/office/clinic (UPMC health care provider staff must fill-in this blank): UPMC LIVER CANCER CENTER*

**1. Required Information**

Patient's Name:	Patient's Date of Birth:	Patient's SSN:	
Patient's Address:		Patient's Phone:	
Name of Patient's Personal Representative:		Personal Rep Phone:	
Personal Representative Address:		Personal Rep Fax:	
Any limitations on issues your personal representative may discuss? Yes _____ No _____ If yes, please specify:			
Expiration date for this designation (unless/until you specify in writing the expiration, this personal representative designation will remain in effect indefinitely):			

**2. Required Signatures**

Personal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_