WELCOME TO THE UPMC LIVER AND PANCREAS CANCER CENTER

PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

PLEASE NOTE: FAILURE TO BRING YOUR COMPLETED NEW PATIENT PAPERWORK WILL RESULT IN A SIGNIFICANT DELAY IN SEEING THE PHYSICIAN AT YOUR SCHEDULED APPOINTMENT TIME.

You are scheduled to have an appointment at the UPMC Liver and Pancreas Cancer Center which is located at the UPMC Hillman Cancer Center, Shadyside Campus, 5115 Centre Avenue, 2nd floor, Pittsburgh PA 15232. There is valet parking on site at a discounted rate of $5.

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.

UPMC
LIFE CHANGING MEDICINE

RAI Screening Assessment

Patient Identification Label

PRINT NAME LAST FIRST M	FORM COMPLETED BY: PATIENT ☐ OTHER ___________

Instructions: Please answer the following questions to the best of your ability. Your advocate or companion can help you complete this survey.

Where You Live

1. Do you live in place other than your own home? ☐ No ☐Yes

If Yes, circle where: Nursing Home Skilled Nursing Facility Assisted Living Other________________

When did you begin living in the place you are currently residing?

Less than 3 months 3 months to 1 year Greater than one year ago

Medical Conditions

2. Any kidney failure, kidney not working well, or seeing a kidney doctor (nephrologist)? ☐ No ☐Yes

If yes circle one: was your nephrologist visit for Kidney stones Other Both Kidney Stones and Other problem

3. Any history of chronic (long-term) congestive heart failure (CHF)? ☐ No ☐Yes

4. Any shortness of breath when resting? ☐ No ☐Yes

Do you have trouble catching your breath when resting or doing minimal activities, like walking to the bathroom?

5. In the past five years, have you been diagnosed with or treated for cancer? ☐ No ☐Yes

Prompt: Please answer "Yes" if the clinic visit today is to discuss the possibility of cancer surgery.

Nutrition

6. Have you lost weight of 10 pounds or more in the past 3 months without trying? ☐ No ☐Yes

Prompt: Are your clothes feeling looser than in the past?

7. Do you have any loss of appetite?

Prompt: Do you or your family notice that you are not eating as much? ☐ No ☐Yes

Cognitive

8. During the last 3 months has it become difficult for you to remember things or organize your thoughts? ☐ No ☐Yes

Activities of Daily Living

9. Getting around (mobility)	Can get around without any help	Needs help from a cane, walker or scooter	Needs Help from others to get around the house or neighborhood	Needs help getting in or out of a chair	Totally dependent on others to get around
10. Eating	Can plan and prepare own meals	Needs help planning meals	Needs help preparing meals	Needs help eating meals	Totally dependent on others to eat meals
11. Toileting	Can use toilet without help	Needs help getting to or from toilet	Needs help to use toilet paper	Cannot use a standard toilet, with help can use bedpan/urinal	Totally dependent on others for toileting
12. Personal hygiene (bathing, hand washing, changing clothes	Can shower or bathe without prompt or help	Can shower or bathe without help when prompted	Needs help preparing the tub or shower	Needs some help with some elements of washing	Totally dependent on others to shower or bathe

Nurse Review:

UPMC-1688 Rev 07252016

UPMC
LIFE CHANGING MEDICINE

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
- ☐ Discharge Summary/Instructions
- ☐ Laboratory Reports/Tests
- ☐ Mammography Report
- ☐ Emergency Dept. Report
- ☐ Medical History & Physical Exam
- ☐ Medication Records
- ☐ Operative Report
- ☐ Pathology Report
- ☐ EKG Report(s)
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Psychiatric/Psychological Eval
- ☐ Radiology Report
- ☐ 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)
Date of Signature	Witness/Staff Member Signature		

***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

05001 12/07

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.

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

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 ALLERGIES 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: ____

____

Personal Representative Designation Form

Dear Patient:
We understand that you wish to appoint a personal representative to act on your behalf as described below. 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.

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

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments. However, unless the personal representative is a licensed physician who is credentialed to provide healthcare services at UPMC, use of UPMC's internal electronic medical record systems to access such medical information is not permitted.

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:

- Procedures/services that require informed consent (and withdrawal of consent if applicable);
- Admissions to and discharges from nursing homes or other long-term care facilities;
- Donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy;
- Continuation or withdrawal of life support; and
- For major health care decisions, a formal power of attorney or living will is required.

This personal representative designation applies to the following UPMC entity/locations:
List all applicable entities:

____

____

REQUIRED INFORMATION:		
Patient's Name:	Patient's Date of Birth:	Patient's Phone:
Patient's Address:		
Name of Patient's Personal Representative:	Personal Representative Phone:	Personal Representative Fax:
Personal Representative Address:		
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 form will remain in effect until the patient no longer receives services at UPMC).		

REQUIRED SIGNATURES:

Personal Representative Signature:____________________ Date: __________

Patient Signature: __________________________Date: __________

OFFICE USE ONLY

Please return this completed form by mail to:

____

____

or by fax to: ________________