UPMC LIFE CHANGING MEDICINE

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 UPMC at Oxford Drive, 400 Oxford Drive, Suite 100, Monroeville, PA. As we are committed to your health and value your time, we ask that you do not report to our clinic any earlier than **15 minutes prior to your actual appointment time.** We must adhere to our set schedule to give every patient our full and undivided attention.

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.

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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)
_____ 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

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

UPMC LIFE CHANGING MEDICINE

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: _____