

WELCOME to the Stead Family Memory Center at Banner Alzheimer's Institute (BAI). As a Center of Excellence focused on the diagnosis, treatment, and study of Alzheimer's disease (and related disorders), we offer a comprehensive approach by an interdisciplinary team of specialists. We understand that memory and thinking problems affect both the person and the family, therefore our services target both.

STEP 1 – COMPLETE THE “NEW PATIENT” PACKET: Please follow the directions provided in the packet. After you've completed the packet, please print the packet and sign the “Authorization to Use or Disclose Protected Health Information” form. Then either fax the packet to our secure line (602) 839-6906 or mail it directly to us at the following address:

Banner Alzheimer's Institute
Stead Family Memory Center
901 East Willetta Street
Phoenix, AZ 85006

STEP 2 – SCHEDULING THE FIRST VISIT: We will call to schedule your visit, once we have received the completed packet. Please plan for a 90 minute visit with our dementia specialty team.

STEP 3 – FOLLOW PRESCRIBED TREATMENT PLAN: After a diagnosis is established, the physician will formulate a treatment plan. The ongoing medical needs will be addressed along with the need for education, support and community resources. Information will also be provided regarding possible participation in clinical research. The medical provider will discuss with you and make a referral to our Family & Community Services Team and an appointment will be scheduled with a Family & Community Services Navigator.

STEP 4 – NEXT RECEIVE A CALL FROM A FAMILY & COMMUNITY SERVICES CONCIERGE: The FCS Concierge will contact you, to discuss all the complimentary services and programs available to you. This is an added value service to you.

STEP 5 – ATTEND EDUCATIONAL CLASSES: You are urged to attend two free classes prior to or following the first clinic appointment; Directions for Caregivers: After the Diagnosis class (formerly COMPASS) to learn the essentials of dementia and caregiving; and Planning Ahead class to understand the important medical, legal and financial decisions that must be addressed. For a full list of education/support programs visit the website at www.banneralz.org and click on “Event Calendar” or inquire with the FCS Concierge which programs are best for you and your family to attend.

We are committed to setting a new standard of care for patients and families. We want to provide an exceptional experience – one that leaves everyone with hope and help! We look forward to seeing you and your family in the very near future!

Sincerely,

Dr. William J. Burke, M.D.
Director, Stead Family Memory Center

Enclosures: New Patient Packet
Authorization to Use or Disclose Protected Health Information

NEW PATIENT PACKET

PATIENT INFORMATION			
Name (First, Middle, Last)		Date of Birth (Required)	
Address		City	State Zip Code
Home Phone	Cell Phone		SSN#
Email Address			
Relationship Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Partner			
Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Ethnic Background: <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other:			

PERSON COMPLETING PACKET (IF DIFFERENT THAN ABOVE)			
Name (First, Middle, Last)		Relationship to patient	
Address		City	State Zip Code
Home Phone		Cell Phone	
Years you have known the patient		Your Age	Today's Date:
How often do you see the patient? <input type="checkbox"/> Every day <input type="checkbox"/> 2 – 3 days per week <input type="checkbox"/> 4 – 6 days per week <input type="checkbox"/> Once every 2 weeks <input type="checkbox"/> Once per month <input type="checkbox"/> Less than once per month			
How many hours a week do you spend with him/her?			
Email address:			
Can we send you e-mail messages? <input type="checkbox"/> Yes <input type="checkbox"/> No			
All email messages will come encrypted to protect confidential patient information			

Can we contact you to set up the new patient appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Your Preferred method of contact? <input type="checkbox"/> Home <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email	
If no, who should we contact?	
Name (First, Middle, Last)	Relationship to patient

NEW PATIENT PACKET

Which is the best method to contact the above named person?			
<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Email:	
Can we leave a message?			
<input type="checkbox"/> YES best method to leave a message	<input type="checkbox"/> Home	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Email
<input type="checkbox"/> NO don't leave a message please			
Dose the patient have a durable <u>Health Care</u> Power of Attorney?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who is so named? Please provide a copy			
Dose the patient have a durable <u>Mental Health</u> Power of Attorney?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who is so named? Please provide a copy			

IF YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE BRING A COPY OF SUPPORTING DOCUMENTS TO INITIAL VISIT.

GENERAL INFORMATION	
Has the patient had a consultation and work up for current symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide their contact information:	
Physician Name:	Phone Number
How long have you been seeing this physician?	Fax Number
Does the patient have a primary care physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide their contact information:	
Physician Name:	Phone Number
How long have you been seeing this physician?	Fax Number
How did you hear about the MEMORY CENTER?	
<input type="checkbox"/> Friend <input type="checkbox"/> Agency <input type="checkbox"/> Physician <input type="checkbox"/> Other:	

PHARMACY INFORMATION	
Local Pharmacy Name	Local Pharmacy Phone
Local Pharmacy Address	
Mail Order Pharmacy Name	ID# (required)
Mail Order Pharmacy Address	

NEW PATIENT PACKET

CURRENT PROBLEM	
What is the main reason for the person's visit to the clinic?	
Is the person aware of why they will be coming to the clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What were the person's initial symptoms and when did they develop?	
When were these initial symptoms first observed?	
Did the symptoms occur suddenly or develop gradually over time?	<input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually
Has the patient ever suffered symptoms of delirium? (periods of extreme confusion or disorientation due to illness, medication side-effects or being in the hospital)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
If you answered yes, please state the approximate year(s) and describe the event(s).	

PEOPLE MAY EXPERIENCE CHANGES IN MANY ABILITIES. HELP US UNDERSTAND THE PERSON'S CURRENT ABILITIES BY MARKING THE BOXES BELOW.

1. MEMORY & THINKING – DOES SHE/HE HAVE PROBLEMS WITH:				
	Never	Sometimes	Often	Always
Recalling recent events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeating questions or stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misplacing items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetting dates or appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking or understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giving up or withdrawing from activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognizing familiar places, people, or objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recalling events in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEW PATIENT PACKET

2. DAILY TASKS – DOES SHE/HE HAVE PROBLEMS WITH:

	Never	Sometimes	Often	Always
Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving or arranging for transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using technology (tools, microwave, computer, thermostat, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Have they had falls? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. PERSONAL CARE AND GROOMING – DOES SHE/HE HAVE PROBLEMS WITH:

	Completely Independent	Verbal reminders	Physical assistance	Completely Dependent
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combing/styling hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applying or removing makeup, if applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing or undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating using utensils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing and swallowing correctly/safely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEW PATIENT PACKET

MOOD AND BEHAVIOR: Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Check the box only if the symptom(s) has been present in the last month.

	Not Applicable	Mild	Moderate	Severe
Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have hallucinations, such as false visions or voices? Does he/she seem to hear or see things that are not present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient resistive to help from others at times or hard to handle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient seem sad, or say that he/she is depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax or feeling excessively tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient appear to feel too good or act excessively happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient seem less interested in his/her usual activities, or in the activities or plans of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them or saying things that may hurt people's feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient lost or gained weight, or had a change in the type of food he/she likes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEW PATIENT PACKET

Please check any of the following words that describe her/his life-long PERSONALITY:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Even tempered | <input type="checkbox"/> Quick tempered | <input type="checkbox"/> Optimistic | <input type="checkbox"/> Pessimistic |
| <input type="checkbox"/> Socially outgoing | <input type="checkbox"/> "Homebody" | <input type="checkbox"/> Worrier | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Assertive | <input type="checkbox"/> Manipulative | <input type="checkbox"/> Complainer |
| <input type="checkbox"/> Hypochondriac | <input type="checkbox"/> Generous/caring | <input type="checkbox"/> Good sense of humor | |

Has her/his personality changed? If so, in what way?

4. SLEEP - DOES SHE/HE HAVE PROBLEMS WITH:

- | | |
|---|--|
| <input type="checkbox"/> "acting out his/her dreams" while sleeping (punching or flailing arms in the air, shouting or screaming) | <input type="checkbox"/> legs repeatedly jerking or twitching <u>during</u> sleep (not just when falling asleep) |
| <input type="checkbox"/> a restless, nervous, tingly, or creepy-crawly feeling in his/her legs that disrupts his/her ability to fall or stay asleep | <input type="checkbox"/> walking around the bedroom or house while asleep |
| <input type="checkbox"/> snorting or choking him/herself awake | <input type="checkbox"/> seem to stop breathing during sleep |

5. JUDGMENT AND SAFETY - DOES SHE/HE HAVE PROBLEMS WITH:

- | | |
|---|---|
| <input type="checkbox"/> Leaving the stove on or microwave fires | <input type="checkbox"/> Wandering off or getting lost |
| <input type="checkbox"/> Leaving the water on | <input type="checkbox"/> Making medication errors |
| <input type="checkbox"/> Having trouble regulating the thermostat | <input type="checkbox"/> Living alone or being left alone |
| <input type="checkbox"/> Having access to weapons | <input type="checkbox"/> Being susceptible to solicitors |

Does the person currently drive a motor vehicle? Yes No

If he/she drives, are you concerned about his/her safety? Yes No

If you answered "Yes" to the question above, please check any of the following areas of concern.

- | | | |
|--|---|--|
| <input type="checkbox"/> Drives too fast | <input type="checkbox"/> Gets angry or flustered | <input type="checkbox"/> Straddles lanes |
| <input type="checkbox"/> Drives too slow | <input type="checkbox"/> Turns in front of other cars | <input type="checkbox"/> Runs overs curbs |
| <input type="checkbox"/> Gets lost | <input type="checkbox"/> Hits objects | <input type="checkbox"/> Doesn't pay attention |
| <input type="checkbox"/> Others: | | |

NEW PATIENT PACKET

WE RECOGNIZE THAT THESE CONDITIONS HAVE A DIRECT IMPACT ON FAMILY CAREGIVERS. IF YOU ARE A CAREGIVER, WHICH OF THE AREAS BELOW CONCERN YOU?

Caregiver Concerns		
Financial/Legal	<input type="checkbox"/> YES	If yes, please describe
Physical Health	<input type="checkbox"/> YES	If yes, please describe
Mental Health	<input type="checkbox"/> YES	If yes, please describe
Managing Problem Behaviors	<input type="checkbox"/> YES	If yes, please describe
Decisions about alternative care options	<input type="checkbox"/> YES	If yes, please describe
Other	<input type="checkbox"/> YES	If yes, please describe

MEDICAL HISTORY

Please list any birth injuries or illnesses:

Please list any childhood and adolescent injuries or illnesses:

Has the patient had a brain scan?

Yes No

If yes, location:

Date:

Has the patient had a stroke?

Yes No

If yes, date(s):

NEW PATIENT PACKET

PLEASE LIST PAST AND CURRENT MEDICAL, NEUROLOGICAL AND PSYCHIATRIC PROBLEMS

PROBLEM	DIAGNOSIS DATE	ACTIVE
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

SURGICAL/HOSPITALIZATION HISTORY		
REASON FOR HOSPITALIZATION	HOSPITAL	DATE

NEW PATIENT PACKET

SYSTEM REVIEW

PLEASE REVIEW THIS AND CHECK "YES" FOR ANY SYMPTOMS THE PATIENT IS EXPERIENCING CURRENTLY

YES	CONSTITUTIONAL
<input type="checkbox"/>	Chills
<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Fever
<input type="checkbox"/>	Malaise (general discomfort)
<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	Weight Gain
<input type="checkbox"/>	Weight Loss

YES	HEENT (HEAD, EYES, EARS, NOSE, THROAT)
<input type="checkbox"/>	Ear Drainage
<input type="checkbox"/>	Ear Pain
<input type="checkbox"/>	Eye Discharge
<input type="checkbox"/>	Eye Pain
<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	Nasal Drainage
<input type="checkbox"/>	Sinus Throat
<input type="checkbox"/>	Visual Changes

YES	RESPIRATORY
<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	Cough
<input type="checkbox"/>	Known TB Exposure
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Asthma

YES	CARDIOVASCULAR
<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	Leg pain with walking
<input type="checkbox"/>	Edema
<input type="checkbox"/>	Palpitations (abnormal heart beats)

YES	GASTRO-INTESTINAL
<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	Blood in Stools
<input type="checkbox"/>	Change in Stools
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Vomiting

YES	GENITOURINARY
<input type="checkbox"/>	Dribbling
<input type="checkbox"/>	Burning with urination
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Excessive urination
<input type="checkbox"/>	Slow Stream
<input type="checkbox"/>	Urinary Frequency
<input type="checkbox"/>	Urinary Incontinence
<input type="checkbox"/>	Urinary Retention

YES	REPRODUCTIVE
<input type="checkbox"/>	Erectile Dysfunction (men)
<input type="checkbox"/>	Penile/Vaginal Discharge
<input type="checkbox"/>	Sexual Dysfunction
<input type="checkbox"/>	Abnormal Pap Smear (women)
<input type="checkbox"/>	Breast discharge or lump (women)
<input type="checkbox"/>	Painful menstrual periods (women)
<input type="checkbox"/>	Pain with intercourse
<input type="checkbox"/>	Hot flashes (women)
<input type="checkbox"/>	Irregular menstrual periods (women)

YES	METABOLIC/ENDO
<input type="checkbox"/>	Brittle Hair
<input type="checkbox"/>	Brittle Nails
<input type="checkbox"/>	Cold Intolerance
<input type="checkbox"/>	Hair changes
<input type="checkbox"/>	Heat Intolerance
<input type="checkbox"/>	Excessive Hair Growth
<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	Excessive eating

YES	NEUROLOGICAL
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Extremity Numbness
<input type="checkbox"/>	Extremity Weakness
<input type="checkbox"/>	Walking or Balance Problems
<input type="checkbox"/>	Headache
<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	Seizures/Convulsions
<input type="checkbox"/>	Tremors
<input type="checkbox"/>	Sudden Loss of Consciousness

YES	PSYCHIATRIC
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Insomnia

YES	SKIN
<input type="checkbox"/>	Contact Allergy
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Mole Changes
<input type="checkbox"/>	Rash
<input type="checkbox"/>	Skin Lesion

YES	MUSCULO-SKELETAL
<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	Joint Swelling
<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	Neck Pain

YES	HEMOTOLOGIC/ LYMPHATIC
<input type="checkbox"/>	Easy Bleeding
<input type="checkbox"/>	Easy Bruising
<input type="checkbox"/>	Swollen glands

YES	IMMUNOLOGIC
<input type="checkbox"/>	Environmental Allergy
<input type="checkbox"/>	Food Allergy
<input type="checkbox"/>	Seasonal Allergy

PHYSICIAN NOTES

NEW PATIENT PACKET

MEDICATION HISTORY
ALLERGIES
Please list allergies to medications:
Please list allergies to foods:
Please list other allergies:

PLEASE LIST ALL MEDICATIONS TAKEN WITHIN THE LAST MONTH:

PRESCRIPTION MEDICATIONS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED

NONPRESCRIPTION MEDICATIONS, SUPPLEMENTS, VITAMINS MEDICATIONS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED

NEW PATIENT PACKET

SOCIAL HISTORY

Years of education completed:		
Previous or current occupation:	Years in occupation:	
Hobbies/Interests		
Number of living children:		
Current living situation:		
<input type="checkbox"/> Alone in home/apt	<input type="checkbox"/> With spouse/family/friend	<input type="checkbox"/> Assisted Living
<input type="checkbox"/> Nursing home	<input type="checkbox"/> Other:	

SUBSTANCE USE HISTORY

ALCOHOL USE

Has the patient ever used alcohol excessively?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current use: How many drinks per week?		
Past use: How many drinks per week?		

TOBACCO USE

Does the patient currently smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, date of cessation:		
If patient ever smoked:	# of packs per day:	# of years smoked:

SUBSTANCE USE

Has the patient ever misused legal or illegal substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:	Type:	Duration:

FOR OFFICE USE ONLY

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NEW PATIENT PACKET

FAMILY HISTORY

DOES THE PATIENT HAVE A BLOOD RELATIVE WITH SYMPTOMS OF OR DIAGNOSIS OF:

Dementia/Senility/Alzheimer's?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, relationship:
Parkinson's?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, relationship:
Strokes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, relationship:
Psychiatric/Mental Illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, relationship:
Mental Retardation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, relationship:
Does the patient have living siblings without Dementia?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list diseases/illnesses in the immediate family:			
Father:			
Mother:			
Sibling #1:			
Sibling #2:			
Sibling #3:			
Sibling #4:			

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I have reviewed the patient packet in its entirety.

Physician Initials: _____ Date: _____



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Label

I authorize _____ to disclose the following information from the health record of: _____ (Health Center/Clinic or Physician Name)

PATIENT INFORMATION
Patient Name
Address
City State Zip
Date of Birth
Phone Number

Dates of Service being Requested:
From: To:

Clinic/ Health Center
Office Visit/Progress notes
Immunization Record
Radiology/Diagnostic Testing
Pathology Reports
Laboratory Reports
Medication List
EKG Report
Consults
Behavior/Psychiatric Office Visits
There may be a FEE associated with a records request.

Delivery of records by: Paper Request Mail Pick Up AND OR Electronic Request: Email CD

Email Address for record delivery

(Complete ONLY is requesting records via Email)
I Do NOT want my electronic record Encrypted I Do want my electronic record Encrypted
Unencrypted data sent by email can be intercepted by unauthorized parties

Purpose
Self Continuing Medical Care Other (Specify Reason):

Information to be Picked Up by or Mailed to:
Company, Person, Facility: Banner Alzheimer's Institute Phone Number : 602-839-6900 fax:602-839-6906
Address: 901 E Willetta St City: Phoenix State: AZ Zip: 852006

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes release of any such information.
I may refuse to sign this authorization form. I understand that Banner Health will not condition or deny treatment on my signing this authorization.
I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Banner Health's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.
Unless I revoke this authorization earlier, it will expire 6 months from the date signed or as specified: I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.
I release Banner Health, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

X
Signature of Patient Date
In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

Signature of Legal Representative Relationship to Patient of Description of Authority to Act for Patient

For Healthcare Use Only
Employee completed/reviewed from with patient: Requestor/Patient Representative ID#:
Verbal Release of View EMR (Document information/person) authorized:
Date Received: Date Sent: Processor:
POA Verified:



1200 HIMS/ROI

Records Picked Up By: Date: