Patient Records

Department

ADMISSION

Last Name

SCAVO

First Name

LYNETTE

Birth Date

1962-12-09

Version: 28 May 2008

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PATIENT ADMISSION

Name SCAVO LYNETTE _____ Date _____
Last First MI

Address _____
Street City State Zip Code

Phone w/area code _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Birth date _____ E-mail Address _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Occupation _____

Employer's Address _____ Your Primary Care Physician _____

Referring Physician _____ Date of your next visit _____

Name of person who should receive statement (other than patient) _____

Statement address (if different than patient's address) _____

Who should we contact in an emergency? _____ Phone number _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING

Primary Insurance _____

Insured's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Insured's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other (location) _____

Involvement in Accident if Auto ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist

Attorney's Name/Address/Phone _____

Insurance Company (worker's comp or your auto PIP) _____

Address _____ Phone number _____

Claim Number _____ Adjuster _____ Name of insured _____

Please tell us how you learned of our service or whom we can thank.

☐ I was a Former Patient ☐ Former Patient recommendation Name _____

☐ Doctor recommendation ☐ Family or Friend recommendation Name _____

☐ Insurance Company recommendation ☐ Employer recommendation ☐ Case Manager recommendation

☐ Health Club recommendation ☐ Newspaper advertisement ☐ Yellow Page advertisement

☐ Clinic Sign ☐ Billboard advertisement ☐ Web page

☐ TV advertisement ☐ Radio advertisement

I learned about you another way. Please explain. _____

PATIENT QUESTIONNAIRE / HEALTH HISTORY

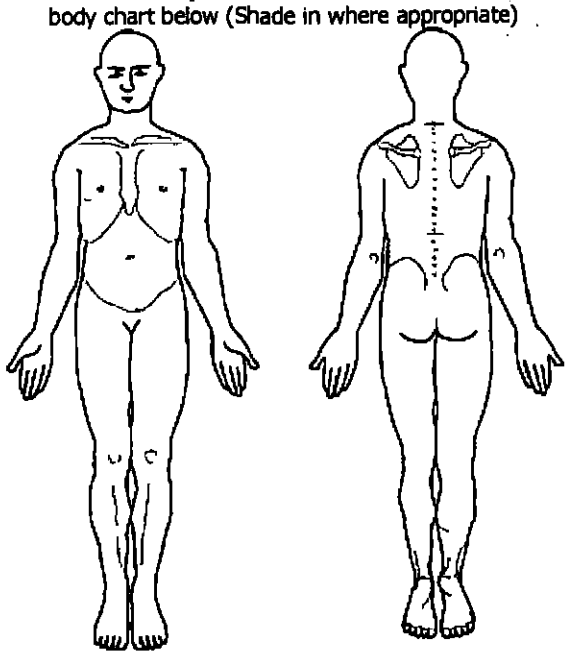
NAME: _SCAVO_____ DATE: _____

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)_____

3. Was the **onset** of this episode gradual or sudden?(Check one)
☐ (1) gradual ☐ (2) sudden

4. Which of the following **best describes** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)

☐ (1) lifting
☐ (2) a MVA (car accident
☐ (3) a fall
☐ (4) overuse (cumulative trauma)
☐ (5) trauma
☐ (6) degenerative process
☐ (7) during recreation/sports
☐ (8) running
☐ (9) a blow to the face
☐ (10) being hit by a ball
☐ (11) a dental appointment
☐ (12) throwing
☐ (13) an incident at work
☐ (14) unknown
☐ (15) other _____

5. Since onset, are your symptoms getting: (Check one)
☐ (1) better ☐ (2) worse ☐ (3) not changing

6. Have you had similar symptoms in the past? (1)☐ Yes (2) ☐ No
More than one episode? (1) ☐ Yes (2) ☐ No

7. Nature of pain/symptoms (check all that apply)
☐ (1) sharp ☐ (4) aching ☐ (7) constant
☐ (2) dull ☐ (5) periodic ☐ (8) other _____
☐ (3) throbbing ☐ (6) occasional _____

8. As the day progresses, do your symptoms: (Check one)
☐ (1) increase ☐ (2) decrease ☐ (3) stay the same

9. Does the pain wake you at night? ☐ (1) No ☐ (2) Yes
if "*yes*", is it present ☐ (1) while lying still
☐ (2) only when changing positions
☐ (3) both

10. Do you have pain/stiffness upon getting out of bed in the *morning*? ☐ (1) Yes ☐ (2) No

11. In what position do you sleep? (Check all that apply)
☐ (1) right side ☐ (4) back ☐ (6) back, sides, stomach
☐ (2) left side ☐ (5) chair/recliner ☐ (7) other _____
☐ (3) stomach

12. Since the onset of your current symptoms have you had:
☐ (1) any difficulty with control of bowel or bladder function
☐ (2) fever/Chills
☐ (3) any numbness in the genital or anal area
☐ (4) numbness
☐ (5) any dizziness or fainting attacks
☐ (6) weakness
☐ (7) unexplained weight change
☐ (8) night pain/sweats
☐ (9) malaise (vague feeling of bodily discomfort)
☐ (10) problems with vision/hearing
☐ (11) none of the above

13. What aggravates your symptoms? (Check all that apply)
☐ (1) sitting
☐ (2) going to/rising from sitting
☐ (3) lying down
☐ (4) walking
☐ (5) up/down stairs
☐ (6) reaching overhead
☐ (6) reaching in front of body
☐ (6) reaching behind back
☐ (6) reaching across body
☐ (7) talking, chewing, yawning, all (*circle one*)
☐ (8) recreation/sports including _____
☐ (9) repetitive activities including _____
☐ (10) household activities including _____
☐ (11) standing
☐ (12) squatting
☐ (13) sleeping
☐ (14) coughing/sneezing
☐ (15) taking a deep breath
☐ (16) looking up overhead
☐ (17) swallowing
☐ (18) stress
☐ (19) sustained bending
☐ (20) other _____

14. What relieves your symptoms? (Check all that apply)
☐ (1) sitting ☐ (6) rest ☐ (11) massage
☐ (2) heat ☐ (7) standing ☐ (12) medication
☐ (3) cold ☐ (8) walking ☐ (13) nothing
☐ (4) stretching ☐ (9) exercise ☐ (14) other_____
☐ (5) wearing a splint/orthosis ☐ (10) lying down _____

Patient Records

Department

BLOODWORK

Version: 21 May 2008

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Patient Name 3000001	Patient Name 3000001	Patient Name 3000001
Patient Name 3000001	Patient Name 3000001	Patient Name 3000001

CLINICAL PATHOLOGY LABORATORY REQUEST FORM

FOR LAB USE ONLY
SPECIMENS RECEIVED:
______________________ (QA Label)
____
ACCN # ______________________

PATIENT NAME (LAST, FIRST, MI) - PLEASE PRINT		SEX ☐ M ☐ F	PATIENT HISTORY #	DOB
PHYSICIAN NAME (LAST, FIRST)	PHONE/PIC #	PHYSICIAN SIGNATURE	PATIENT LOCATION	DATE & TIME OF COLLECTION

CHECK APPROPRIATE BOX FOR BILLING
☐ WHOLESALE ACCOUNT W______________
☐ INSURANCE BILLING: COMPLETE SECTION 1-6 BELOW
☐ PATIENT BILLING (SELF PAY): COMPLETE SECTION 1-2 BELOW

XXXXXXX

1. PATIENT ADDRESS (STREET OR PO BOX)		CITY/STATE		ZIP CODE
2. PATIENT PHONE #	PATIENT SOCIAL SECURITY #		PATIENT MARITAL STATUS ☐ S ☐ M ☐ W ☐ D	RACE ☐ W ☐ B ☐ OTHER
GUARANTOR NAME (LEAVE BLANK IF PATIENT IS GUARANTOR)	GUARANTOR PHONE #		RELATIONSHIP TO PATIENT	
GUARANTOR ADDRESS (STREET OR PO BOX)	CITY/STATE			ZIP CODE
3. MEDICARE: PRIMARY/SECONDARY	MEDICARE # & LETTER	4. MEDICAID #	STATE	EFFECTIVE DATE
OTHER INSURER ☐ PRIMARY ☐ SECONDARY	COMPANY NAME	ADDRESS		PHONE #
EFFECTIVE DATE	SUBSCRIBER NAME	POLICY #	GROUP #	

ICD9 CODE	TEST NAME	TEST CODE
______	☐ ALBUMIN	(ALB)
______	☐ ALKALINE PHOSPHATASE	(ALKP)
______	☐ ALT (GPT)	(ALT)
______	☐ ANA*	(ANAHU)
______	☐ AST (GOT)	(AST)
______	☐ B/T CELL SUBSETS* (FLOW)	(CDØ)
______	☐ BILIRUBIN, TOTAL	(TBIL)
______	☐ BUN	(BUN)
______	☐ CALCIUM	(CA)
______	☐ CARBAMAZEPINE	(CARBMZ)
______	☐ CARDIOLIPIN IgG & IgM ANTIBODIES	(ANTICA)
______	☐ CBC w/ PLATELETS ☐ STAT	(CBC)
______	☐ CBC w/ PLATELETS & DIFF(1) ☐ STAT	(CBCPR)
______	☐ CEA	(CEA)
______	☐ CHEM PANEL, BASIC METAB. ☐ STAT	(CPBAS)
______	☐ CHEM PANEL, COMPREHENSIVE	(CPCOM)
______	☐ CHEM PANEL, ELECTROLYTES	(CPELEC)
______	☐ CHEM PANEL, HEPATIC	(CPHEP)
______	☐ CMV IgG SCREEN	(CMVSCR)
______	☐ CK	(CPK)
______	☐ CORTISOL	(CORT)
______	☐ CREATININE	(CREA)
______	☐ C REACTIVE PROTEIN	(CRP)
	CSF PANEL, order separately ☐ STAT	(CSFPAN)
______	☐ CSF GLUCOSE ☐ CSF PROTEIN	
______	☐ CSF PROFILE ☐ STAT	(CSFPR)
______	☐ CYCLOSPORIN	(CYCLOS)
______	☐ DIGOXIN	(DIGOX)
______	☐ DS DNA (crithidia)*	(ANTIDN)
______	☐ EBV IMMUNE STATUS	(EBVIM)
______	☐ FERRITIN	(FERITN)
______	☐ FK506 / TACROLIMUS	(FK506)
______	☐ FOLLICLE STIMULATING HORMONE	(FSH)
______	☐ FOLATE	(FOLATE)
______	☐ GLUCOSE ☐ STAT	(GLUC)
______	☐ HEMOGLOBIN A1C	(HGBA1C)
______	☐ HCG, QUALITATIVE	(HCGQL)
______	☐ HCG, QUANTITATIVE	(HCGQN)
______	☐ HGB, ELECTROPHORESIS*	(HGBEP)
______	☐ HEP C VIRAL LOAD (QUANT.)	(HEPCVL)
______	☐ HIV ANTIBODY*	(HIV12)

ICD9 CODE	TEST NAME	TEST CODE
______	☐ HIV VIRAL LOAD (QUANT.)	(HIVVL)
______	☐ LOW HIV VIRAL LOAD	(LHIVVL)
	HEPATITIS, A, B, C order separately	
______	☐ HBsAg*	
______	☐ HBsAb	
______	☐ HBcAb	(HEPB)
______	☐ HCVAb	(HEPEH)
______	☐ HAVM	(HEPP)
______	☐ IG QUANTITATION (IgG, IgA, IgM)	(QUANT)
______	☐ INSULIN-LIKE GROWTH FACTOR	(IGFI)
______	☐ IRON	(IRON)
______	☐ IRON & TRANSFERRIN	(FETRAN)
______	☐ LDH	(LDH)
______	☐ LIPID (CHOL, HDL, LDL, TRIG, VLDL) (may be ordered separately)	(LIPID)
	☐ (CHOLB) CHOLESTEROL ☐ (HDLB) HDL-CHOLESTEROL ☐ (TRIGB) TRIGLYCERIDE	
______	☐ LITHIUM	(LITH)
______	☐ LUTEINIZING HORMONE	(LUH)
______	☐ MAGNESIUM	(MG)
______	☐ MONO TEST	(MONOSL)
______	☐ OVARIAN CANCER ANTIGEN	(OCA125)
______	☐ PARATHYROID HORMONE ☐ CALCIUM	(PTHINT)(CA)
______	☐ PARTIAL THROMBOPLASTIN ☐ STAT	(PTT)
______	☐ PHENOBARBITAL	(PHENO)
______	☐ PHENYTOIN	(PTN)
______	☐ PHOSPHOROUS	(PHOS)
______	☐ POTASSIUM	(K)
	PRENATAL PANEL, order separately	
______	☐ CBC ☐ RPR* ☐ HBsAg* ☐ RUBELLA IgG ☐ HIV12	
______	☐ PROTEIN ELECTROPHORESIS*	(SPEP)
______	☐ PROTHROMBIN TIME-INR ☐ STAT	(PT)
______	☐ PROLACTIN	(PRL)
______	☐ PROSTATE SPECIFIC ANTIGEN (DIAG)	(PSA)
______	☐ PROSTATE SPECIFIC ANTIGEN (SCRN)	(PSASC)
______	☐ RETICULOCYTES	(RETICS)
______	☐ RHEUMATOID FACTOR	(RF)
______	☐ RPR*	(RPR)
______	☐ SEDIMENTATION RATE	(ESR)
______	☐ SODIUM	(NA)
______	☐ TESTOSTERONE	(TESTOS)

ICD9 CODE	TEST NAME	TEST CODE
	THYROID PANEL, order separately	
______	☐ T3U ☐ T4 ☐ TSH	
______	☐ TSH w/reflex Free T4 (Orders Free T4 if > 6.4 or < 0.4)	(TSHR)
______	☐ TOTAL HEMOLYTIC COMPLEMENT	(CH50)
______	☐ TOTAL PROTEIN	(TP)
______	☐ TRANSFERRIN	(TRF)
______	☐ TROPONIN I	(TROPI)
______	☐ TROPONIN w/reflex MB (Orders CKMB if > 0.1)	(TNIMB)
______	☐ URIC ACID	(URIC)
______	☐ VALPROATE	(VALP)
______	☐ VITAMIN B12	(B12)

URINE TESTING

ICD9 CODE	SPOT	TIMED
______	☐ URINE TOTAL PROTEIN (UTP)	☐ ____ HR (UTFTP)
______	☐ CALCIUM (UCALCM)	☐ ____ HR (UTFCA)
______	☐ CREATININE (UCREA)	☐ ____ HR (UTFCRE)
______	☐ MICROALBUMIN (MALB)	☐ ____ HR (MALB)
______	☐ ALBUMIN/CREATININE RATIO	☐ ____ HR (UACR)
______	☐ PROTEIN ELECTROPH.* (UPEPSP)	☐ ____ HR (UPEPTP)
	CREATININE CLEARANCE	☐ ____ HR (CRCL)
______	☐ URINE FREE CORTISOL	☐ ____ HR (UFCORT)
______	☐ CATECHOLAMINES**	☐ ____ HR (UCAT)
______	☐ METANEPHRINES & NORMET	☐ ____ HR (UMN)
______	☐ VANILMANDELIC ACID**	☐ ____ HR (UVMA)
______	☐ URINALYSIS* ☐ STAT	(UASCR)
______	☐ URINE CULTURE/SUSCEPT.	(UC)

Collect method ______________ Total volume ________

CULTURE

ICD9 CODE	TEST NAME	TEST CODE
______	☐ RAPID GRP A BETA SREP SCRN (Culture performed on negative)	(TS)
______	☐ GRP A BETA STREP, CULTURE	(CTS)
	CHLAMYDIA/GC SCREEN, order separately	
______	☐ CHLAMYDIA SCR (CLAPRB) ☐ GC SCR	(GCPRB)
______	☐ OTHER ROUTINE TEST	

____
____

CIRCLE ONE:
PHONE / FAX RESULTS TO: ______________

NOTE: *Denotes tests that will have automatic confirmation performed upon positive screen result unless otherwise indicated.
(1) Abnormal cellular findings may result in a professional fee for pathologist review.

Patient Records

Department

PHARMACY

Version: 21 May 2008

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JOOS

AAN TE VULLEN DOOR DE GERECHTIGDE

HIERNA INVULLEN OF KLEEFBRIEFJE V.I. AANBRENGEN

Naam en voornaam van de gerechtigde/patiënt : .....

.....

Verzekeringsinstelling : .....

Inschrijvingsnummer : ⌊⌊⌊⌊⌊⌊⌊⌊⌊⌊⌊⌊⌋⌋

Adres van de gerechtigde : .....

.....

GETUIGSCHRIFT VOOR VERSTREKTE HULP

IN TE VULLEN DOOR DE VERSTREKKER

Naam en voornaam van de patiënt : Thomas

Gerechtigde - Echtgenote - Kind - Ascendent (1)

Raadpleging – Bezoek (2)

Datum : 5/6/20 Nomenclatuur nr. : 101576

Reiskosten : .....

Andere verstrekkingen (2)

Datum van de verstrekking	Nummer v. d. nomenclatuur	Voorbehouden aan V.I.	Datum van de verstrekking	Nummer v. d. nomenclatuur	Voorbehouden aan V.I.
					(2)

Voorgeschreven door : .....
(Naam en voornaam)

op datum van : ...../...../.....

R.I.Z.I.V. - identificatienummer van de voorschrijver : ⌊⌋/⌊⌊⌊⌊⌋⌋ ⌊⌊⌋⌋ ⌊⌊⌊⌋⌋

Laboratorium of apparatuur of dienst erkend onder nummer : ⌊⌊⌊⌊⌊⌋⌋ ⌊⌊⌋⌋ ⌊⌊⌊⌋⌋

Datum van ontvangst van het voorschrift : ...../...../.....

Patiënt is gehospitaliseerd / ambulant (1) :

Nummer van de instelling : ⌊⌋/⌊⌊⌋⌋/⌊⌊⌊⌋⌋/⌊⌊⌋⌋

Dienst : ⌊⌊⌋⌋

(1) Schrappen wat niet past.
(2) De niet gebruikte vakken doorhalen.

K.B. 15.07.2002

..... EUR

Identificatie van de verstrekker :

Dr Luc Roland
St-Damiaanstraat 15
2160 Wommelgem
1 18163 80 004
03 353 71 34

Datum : 5/6/20

Handtekening van de verstrekker.

0359843

Dr Luc Roland
St-Damiaanstraat 15
2160 Wommelgem
1 18163 80 004
03 353 71 34

ONTVANGSTBEWIJS

Datum : 5/6/20

Handtekening van de verstrekker.

Ontvangen de som van : 23 EUR

0359843

Pharmacy Stamp

Age
26

D.o.B
24/04/1981

Please don't stamp over age box

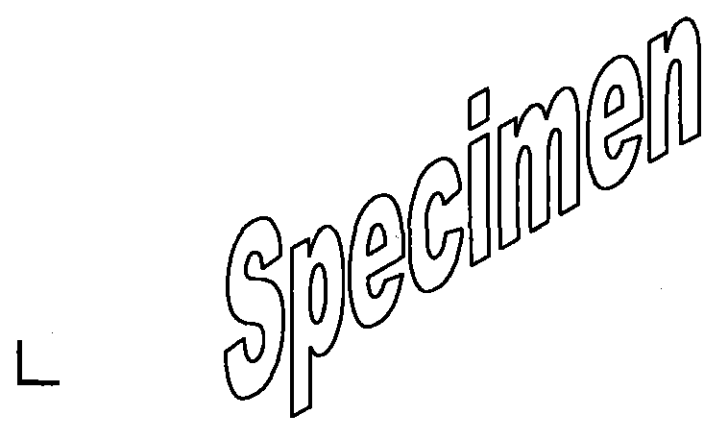
Title, Forename, Surname & Address
MS SCAVO LYNETTE

ADDRESS LINE 1
ADDRESS LINE 2
ADDRESS LINE 3
ADDRESS LINE 4 **OB1 1OB**

NHS Number: **1234567890**

Number of days' treatment
N.B. Ensure dose is stated

Endorsements **PHARMACIST REPEAT DISPENSING** **RD**



Sign of Prescriber

Date

Repeat Dispensing: 6 of 12 **6**

For dispenser No. of Prescns. on form

MS SCAVO **12C3456A** **RD**

PCT NAME **51A00**
PATIENT'S PRACTICE CODE: **A12345**
PCT ADDRESS LINE 1
PCT ADDRESS LINE 2 NE5 1ZZ
PRESCRIBER CONTACT NUMBER: 0910 4567001

NHS

FP10SS0406

PRINTED SERIAL NUMBER

Patient Records

Department

PODIATRY

Version: 21 May 2008

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Demo Documents

Basic Foot Assessment Checklist

1. Ask the patient	neuropathic symptoms	Y	N	
	rest pain	Y	N	
	intermittent claudication	Y	N	
	previous foot ulcer	Y	N	
	amputation	Y	N	
	specify SITE_____			DATE ___/___/___

2. Look at both feet	infection	Y	N		
	ulceration	Y	N		
	calluses or corns	Y	N		
	skin breaks	Y	N		
	nail disorders	Y	N		

		LEFT		RIGHT	
3. Check foot pulses	Dorsalis pedis	Y	N	Y	N
	Posterior tibial	Y	N	Y	N

		LEFT		RIGHT	
4. Test for neuropathy	Monofilament *	Y	N	Y	N

**detected at sites marked*

Left   Right

5. Assess footwear	style	Good	Poor
	condition	Good	Poor
	fit	Good	Poor

6. Assess education need

Does the patient understand the effects of diabetes on foot health ?	Y	N
Can the patient identify appropriate foot care practices ?	Y	N
Are the patient's feet adequately cared for ?	Y	N

7. Assess self care capacity

Does the patient have impaired vision ?	Y	N
Can the patient reach own feet for safe self care ?	Y	N
Are there other factors influencing ability to safely care for own feet ?	Y	N

All people with diabetes need to have their feet assessed with these 7 simple steps every 6 months or more often if problems are identified

Patient Records

Department

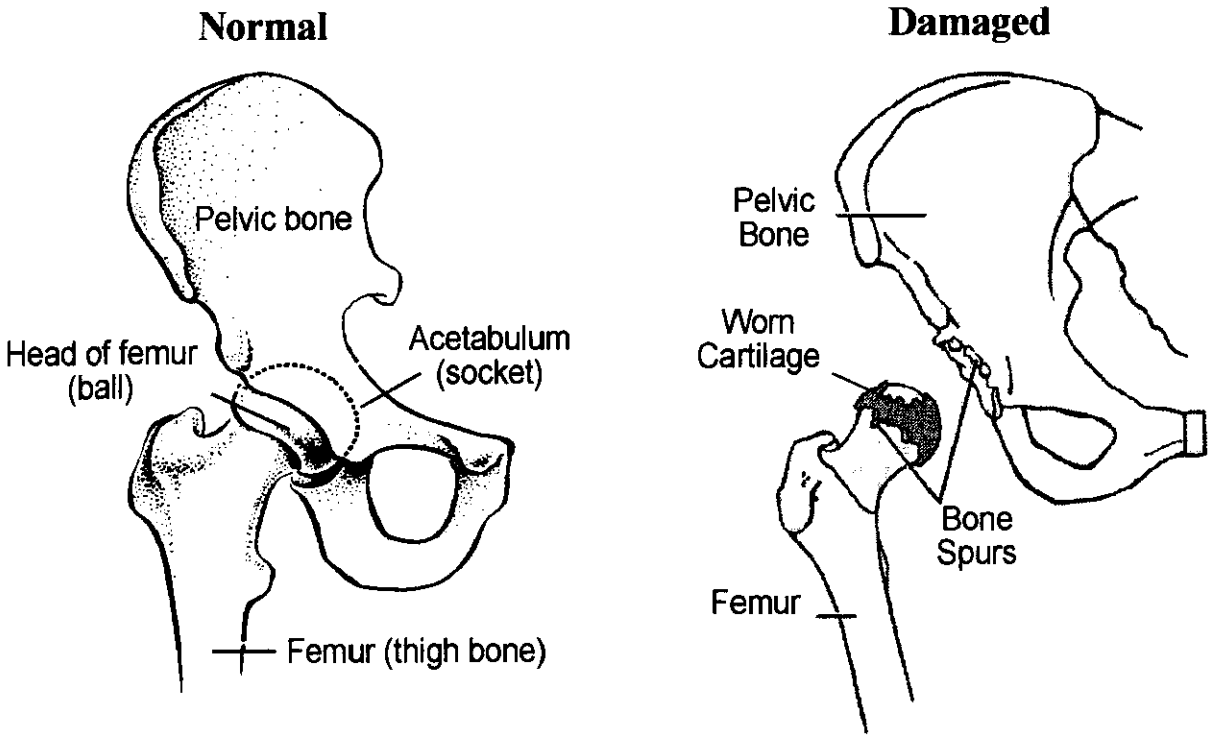
SURGERY

Version: 21 May 2008

KOFAX

Demo Documents

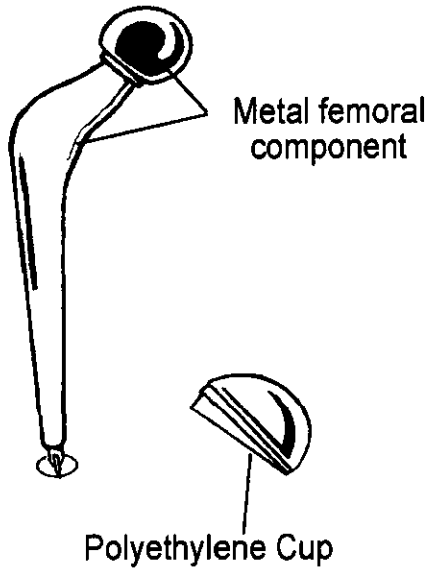
Types of Hip Replacements



Total hip replacement (THR) (also called total hip arthroplasty, THA) consists of two parts.

1. **Femoral (ball and stem) component** - the ball and stem fits into the femur or thigh bone.

2. **Acetabular (socket) component** - the acetabular component fits into the socket in the pelvic bone.



There are two ways in which your joint replacement may be held in place: 1) with bone cement, or 2) by having your bone grow into it.

In Cemented or Hybrid Joints

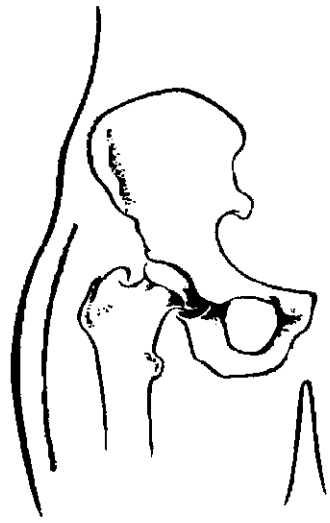
One or both components are held in place by a special bone cement (methyl methacrylate). This cement is pressed into the small nooks and crannies of the bone to form a bond between the metal and the bone. The cement hardens immediately allowing early weight bearing and walking following surgery.

Uncemented ("porous coated") joints

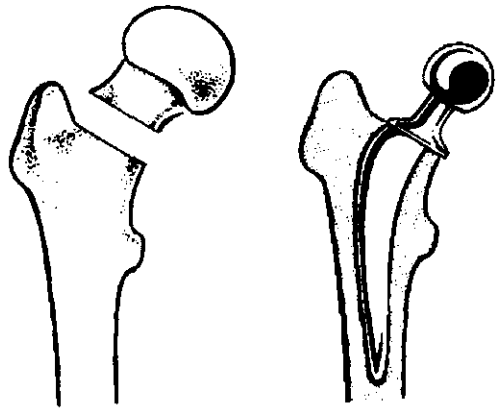
In an uncemented replacement, the components are coated with thousands of tiny beads. These beads provide a huge network of nooks and crannies into which new bone can grow. This provides a direct bone to metal bond without cement. The new bone takes 6-12 weeks to grow and it may be necessary to protect the growing bone. For this reason, you may be required to keep your weight off the new joint and use crutches or a walker while you are healing.

The Surgical Procedure for Total Hip Replacement

The incision is usually made over the top of the femur (thigh bone). The muscles that hold the hip in place are partially detached. The ball of the femur is then removed from the acetabulum (pelvic socket). The damaged cartilage and bone are cleaned away. The new socket cup is then fixed in place in the pelvic socket.



The head (ball) at the end of the femur (thigh bone) is then removed. Some bone marrow is removed from the hollow of the femur so that the metal stem can be placed.



The new hip is put together and the muscles and skin are sewn in place with sutures and or staples. The hip is then tested for movement and stability. The surgery usually takes about 1.5 hours.