GAMMA WEST CANCER SERVICES
Taking Cancer Personally

# PATIENT REGISTRATION

## Contact Information

Name _____

Address _____
Street City State Zip

Date of Birth _____ Age_____

Home Phone _____ Cell Phone _____

Email Address_____

Referring Physician _____ Phone _____

Primary Care Physician_____ Phone _____

Emergency Contact_____ Relation_____ Phone _____

**Attention: We will use the address above and all phone numbers and addresses listed to contact you, mail copy of office visit notes and/or leave messages, and speak to friends or family involved in your care. Please see the Office Manager if you wish to place a restriction on the use of this information for these purposes.**

## Personal Information

Male ____ Female ____ Marital Status (circle one) S M D W

Ethnic Origin: Caucasian ___ African American ___ Hispanic ___ Asian ___ Native American ___

Ethnicity: Hispanic/Latino ___ Not Hispanic/Latino___ Decline to Answer_____

Spoken Language_____ Preferred Language_____

## Insurance Information

Have you been, or are you currently in a nursing facility? ☐ Yes ☐ No

Are you on Hospice? ☐ Yes ☐ No

If yes, what were the dates? _____

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Taking Cancer Personally

**Primary Insurance**

Name of Insurance_____

Subscriber _____ DOB _____

Member ID _____ Group# _____ Effective Date_____

Guarantor Name _____ Relation to Patient _____
(Person responsible for payment if other than patient)

Address _____ Phone Number _____

**Secondary Insurance**

Insurance _____

Subscriber _____ DOB _____

Member ID _____ Group# _____ Effective Date_____

Guarantor Name _____ Relation to Patient _____
(Person responsible for payment if other than patient)

Address _____ Phone Number _____

**I agree that all of the information above is accurate and current. My signature indicates that I fully understand and agree to the above terms. I further grant authorization for all evaluations and diagnostic procedures performed.**

_____

Patient Signature Date

_____

Guarantor's Signature (if other than patient) Date

## CONSENT TO PHOTOGRAPH

**"I consent to be photographed for the purpose of patient identity in my medical records and imaging for treatment purposes. I understand that the photographs or images will not be published for any purpose without my prior written consent."**

_____

Patient Signature Date

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

**(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)**

I authorize Any & All Medical Entities (healthcare providers) to release my medical records to the following individual or entity:

Name of Entity: GammaWest Cancer Services

Address: _____
Street City State Zip

Patient Name: _____ DOB: _____ SS# _____
Optional

This authorization for release of information covers the period of healthcare:

☐ All Past, Present, and Future Periods ***OR*** ☐ From: _____ To: _____
Date Date

☐ I authorize the release of my **complete health records** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

***OR***

I authorize the release of my complete health record **with the exception** of the following information:

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment ☐ Other (please specify): _____

The purpose of this release: _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effective for 90 days from the date of my signature below.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether or not I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Patient or Personal Representative Relationship to the Patient

# MEDICARE LIFETIME ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made to me or on my behalf to GammaWest Cancer Services (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.

Patient/Guardian Signature: _____ Date: _____

## Medi-gap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medi-gap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medi-gap insurer listed below any information needed to determine benefits payable for services from the Provider. This assignment is effective until evoked by me in writing.

Medi-gap Insurance Name: _____

Patient/Guardian Signature: _____ Date: _____

## General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: _____ Date: _____

GAMMA WEST CANCER SERVICES
Taking Cancer Personally

## NOTICE OF HIPPA PRIVACY PRACTICES

I acknowledge that I have been offered/given a copy of the GammaWest Cancer Services Notice of Privacy Practices. I understand that if I have questions or concerns, I may contact the Facility Privacy Official.

_____ _____

Patient Signature Date

**********

## DISCLOSURE OF FINANCIAL INTEREST

Because of concerns there may be conflict of interest when a physician refers a patient to a healthcare facility for other treatment in which the physician has a financial interest, the State of Utah passed a law. The law requires that I disclose this financial interest to you and provide and state that you may choose any facility or service center for the purpose of having this treatment performed. This disclosure is intended to help you make a fully informed decision about your health.

For more information about alternative providers, please ask me or my staff.

The physicians at GammaWest Cancer Services or their family member(s) have a financial interest in GammaWest which provides brachytherapy service.

### ACKNOWLEDGMENT

I have read and understand the above notice.

_____ _____

Patient Signature Date

GAMMA WEST CANCER SERVICES
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# ARBITRATION AGREEMENT

**Article 1 Dispute Resolution**

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

**Article 2 Definitions**

A. The term "we", "parties", or "us" means you, (the Patient), and the Provider.
B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.
C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors, and estates.
D. The term "Patient" or "you" means:
    1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents, or legal representatives, AND
    2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

**Article 3 Dispute Resolution Options**

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
    1) working directly with each other to try and find a solution that resolves the Claim, OR
    2) using non-binding mediation (each of us will bear one-half of the costs), OR
    3) using binding arbitration as described in this Agreement.

    You may choose to use any or all of these methods to resolve your Claim.
B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
C. Arbitration – Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

**Article 4 How to Arbitrate a Claim**

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail, it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
    1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
    2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.
E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators, but is considered a "Provider" for all other purposes of this Agreement.

**Article 5 Liability and Damages May Be Arbitrated Separately**
At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

**Article 6 Venue/Governing Law**
The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

**Article 7 Term/Rescission/Termination**

A. **Term**. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
B. **Rescission**. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E).
C. **Termination**. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

**Article 8 Severability**
If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

**Article 9 Acknowledgement of Written Explanation of Arbitration**
I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

**Article 10 Receipt of Copy**.
I have received a copy of this document.

| **Provider** | **Patient** |
|---|---|
| GammaWest Cancer Services<br>Name of Physician, Group, or Clinic | _____<br>Name of Patient (Print) |
| _____<br>Signature of Physician or Authorized Agent | _____<br>Signature of Patient or Patient's Representative |
| _____<br>Date | _____<br>Date |

# E-MAIL CONSENT FORM

_____

Patient's name (printed)

_____

Patient's home address

_____ _____

Patient's e-mail address | Patient's home phone number

_____

Patient's cell phone number | Cell phone provider

**DO NOT USE EMAIL FOR EMERGENCY, URGENT & SENSITIVE PROBLEMS!**

**E-mail should never be used for emergency or urgent problems**. **For a life-threatening emergency, call 911**. **For urgent or sensitive problems, call the office at 801- 456- 8401**. We recommend office visits for all new, complex or sensitive problems. When we are not in the office, the answering message will direct you to an on-call doctor who can give advice or direct you to a source of emergency or urgent care.

## 1. RISKS OF USING E-MAILTO COMMUNICATE WITH YOUR PROVIDER

The term "Provider" in this consent refers to GammaWest Cancer Services and the staff. The Providers offer patients the opportunity to communicate by e-mail. However, transmitting patient information by e-mail has risks that patients should consider. Risks include, but are not limited to:

- E-mail can be circulated, forwarded, and stored in paper and electronic files.
- E-mail can be broadcast worldwide or can be received by unintended recipients at home or at work.
- E-mail senders can accidentally type the wrong email address or send to others besides the intended recipient.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be used as evidence in court.
- E-mail can introduce viruses or worms into computer systems.

## 2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must give signed consent to the use of patient information in e-mail, indicating agreement with these conditions:

- All e-mails to or from the patient concerning treatment will be added to the patient's medical record. Therefore, other individuals authorized to access the medical record will have access to those e-mails.
- Provider may forward e-mails internally to Provider's staff as necessary for treatment, payment, and operations. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Provider or staff shall confirm when an e-mail from the patient has been received and read. However, the patient shall not use e-mail for medical emergencies, urgent problems or other time sensitive matters.
- If the patient's e-mail requires or requests a response from Provider, and the patient has not received a response within 3 days, the patient is responsible to follow up to determine whether the intended recipient received the e-mail and when he/she will respond.
- The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- The patient is responsible for informing Provider of any other types of information the patient does not want to be sent by e-mail.
- The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

- Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines or treating patients who have not first been seen in the office.
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

**3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS**

To communicate by e-mail, the patient shall:

- Limit or avoid use of his/her employer's computer.
- Inform Provider of changes in his/her email address.
- Confirm that he/she has received and read an e-mail from the Provider.
- Put the patient's name in the body of the e-mail.
- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider.
- Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by e-mail or written communication to Provider.
- E-mail should be brief, and to the point.

**4. ALTERNATE FORMS OF COMMUNICATION**

I understand that I may also communicate with the Provider via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. If no response from email is received after 3 days, the patient should call the office.

**5. TYPES OF E-MAIL TRANSMISSIONS THAT PATIENT AGREES TO SEND AND/OR RECEIVE**

Types of information that can be communicated via e-mail with the Provider include prescription refills, referral requests, appointment scheduling requests, billing and insurance questions, patient education, and clinical consultation. If you are not sure if the issue you wish to discuss should be included in an e-mail, please call Provider's office to schedule an appointment.

**6. HOLD HARMLESS**

I agree to indemnify and hold harmless the Provider, GammaWest Cancer Services, its employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider or to use Provider's Web Site **gammawest.com**, any arrangements made based on information obtained at the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The Provider does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the Provider's Site or the server that makes the Site available is free of viruses or other harmful components.

**7. TERMINATION OF THE E-MAIL RELATIONSHIP**

Provider has the right to immediately terminate the e-mail relationship with a patient if he/she determines, in his/her sole discretion, that patient has violated the terms and conditions set forth above or otherwise breached this agreement, or has engaged in conduct which the Provider determines, in his/her sole discretion, to be unacceptable. The e-mail relationship between the Provider and the patient will terminate in the event the Provider, in his/her sole discretion, no longer wishes to utilize the e-mail to communicate with all of his/her patients. Patient also has the right to terminate the email relationship by written notice to Provider, at any time.

## PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form and discussed it with the Provider or his/her representative. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I had were answered.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Taking Cancer Personally

# GENERAL HEALTH HISTORY

| Patient Name: | | | | Date of birth: | |
|---|---|---|---|---|---|
| Age: | Sex: | Married: | Height: | Weight: | Race: |
| Current Cancer Diagnosis: | | | | | |

| **General** | | | |
|---|---|---|---|
| | **YES** | **NO** | **COMMENTS** |
| Have you ever been diagnosed with cancer before? If yes, what type of cancer and were you treated with radiation or chemotherapy? | | | |
| Do you have or have you had any illness of which your doctor should be aware? | | | |
| Have you had a flu shot? | | | |
| Have you ever had a serious injury? | | | |
| List all surgeries that you have had:<br>_____ _____<br>_____ _____<br>_____ _____<br>_____ _____ | | | |
| Are you taking any hormone medications or receiving any hormone injections? If yes, please specify (i.e. Lupron, Bicalutamide, Firmagon, Estrogen) | | | |
| **Family History** | | | |
| Do you have a family history of cancer? If yes, please explain.<br>Parent:_____<br>Parent:_____<br>Sibling:_____<br>Sibling:_____<br>Other:_____ | | | |
| **Tobacco/Drug/Alcohol History** | | | |
| Do you now or have you ever abused drugs? | | | |
| Are you currently using tobacco? | | | |

| | YES | NO | COMMENTS |
|---|---|---|---|
| Have you ever been a user of tobacco? | | | |
| How many pack/day and for how many years? | | | |
| Tell us about the amount of alcohol you currently use or have used in the past: | | | |
| **Weight Change** | | | |
| Have you had any weight change in the past 3 months? | | | |
| **Fatigue** | | | |
| Do you have fatigue? How would you describe your energy level? (Decreased, Normal, Increased) | | | |
| **Vision** | | | |
| Do you have any problems with your eyes or vision? If yes, please explain. | | | |
| Do you wear glasses or contacts? | | | |
| **Ears** | | | |
| Do you have any problems with your ears or hearing? If yes, please explain. | | | |
| Do you wear hearing aids? | | | |
| Do you have ringing in your ears? | | | |
| **Nose** | | | |
| Do you have any problems with your nose? If yes, please explain. | | | |
| **Throat** | | | |
| Do you have any problems with your throat? If yes, please explain. (i.e. hoarseness) | | | |
| Do you have difficulty swallowing? | | | |
| **Cardiovascular** | | | |
| Does your doctor need to know anything about your heart? (i.e. arrhythmia, high blood pressure, etc.)<br>If yes, please explain. | | | |
| Have you ever had a heart attack? | | | |
| Have you ever had a stroke? | | | |
| Do you have a pacemaker? | | | |
| **Respiratory** | | | |
| Do you have any respiratory problems or illnesses the doctor should know about? (i.e. asthma, shortness of breath) If yes, please explain. | | | |
| Do you use oxygen at home? If yes, how many liters? | | | |
| **Gastrointestinal** | | | |
| Do you have any problems with your stomach or bowels? If yes, please explain. | | | |
| Have you had a colonoscopy? Was it normal and was it done in the last 9 years? | | | |

| | YES | NO | COMMENTS |
|---|---|---|---|
| **GYN Genitourinary (Females Only)** | | | |
| Have you taken any hormones in the past? | | | |
| Age of first menstrual period | | | |
| Menopause history, at what age? | | | |
| Tell us about your pregnancy history, number of pregnancies and number of live births. | | | |
| Have you recently had a pap smear?<br>Date of last pap smear | | | |
| Any pelvic problems (i.e. pain, infections, organ prolapse) | | | |
| | | | |
| Have you recently had a mammogram?<br>Date of last mammogram | | | |
| Have you noticed any problems with your breasts?<br>If yes, please explain. | | | |
| **Skin** | | | |
| Do you have any problems with your skin or had excessive sun exposure? | | | |
| **Musculoskeletal** | | | |
| Are you having any problems with your bones, joints, or muscles? If yes, please explain. | | | |
| Do you have arthritis?<br><br>Location of arthritis | | | |
| **Neurological** | | | |
| Do you have any neurological problems the doctor needs to know about? If yes, please explain. | | | |
| Do you have headaches?<br>If yes, how often? | | | |
| Have you noticed numbness or tingling in your fingers or toes? | | | |
| Do you have seizures? | | | |
| Do you have problems with dizziness? | | | |
| Have you fallen recently? | | | |
| **Psychological** | | | |
| Do you feel depressed or are you being treated for depression? | | | |
| **Thyroid** | | | |
| Do you have a history of thyroid disease? | | | |
| **Diabetes** | | | |
| Are you a diabetic?<br>How do you control your diabetes? | | | |
| **Advanced Directives** | | | |
| Do you have a Healthcare Proxy? | | | |
| Do you have a Living Will? | | | |

GAMMA WEST CANCER SERVICES
Taking Cancer Personally

# MEDICATION LIST

| Name of Medication/Vitamin | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies:**_____

**Preferred Pharmacy:**_____
Phone number (if known)

**Patient Name:**_____ DOB_____

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Taking Cancer Personally

# INTERNATIONAL PROSTATE SYMPTOM SCORE (circle **one** number on each line)

Patient Name _____ Date_____

| Questions to be answered | Not at all | Less than 1 time in 5 | Less than half the time | About half the time | More than half the time | Almost always |
|---|---|---|---|---|---|---|
| 1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Over the past month, how often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Over the past month, how often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Over the past month, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Over the past month, how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? | 0 (None) | 1 (1 time) | 2 (2 times) | 3 (3 times) | 4 (4 times) | 5 (5 times or more) |

**Sum of 7 circled numbers (IPSS SCORE): _____**

GAMMA WEST CANCER SERVICES
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## URINARY BOTHER SCORE

| | Delighted | Pleased | Mostly Satisfied | Mixed | Mostly Dissatisfied | Unhappy | Terrible |
|---|---|---|---|---|---|---|---|
| How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

**Do you have a tremor?** ☐YES ☐ NO

**If yes, is it due to one of the following?**

Parkinson's Disease? ☐YES ☐NO
Stroke? ☐YES ☐NO
Familial? ☐YES ☐NO
Other? ☐YES ☐NO

**If yes to other, please provide explanation for tremor.**

_____

_____

_____

# International Index of Erectile Function (IIEF-5) Questionnaire

**Patient Name:**_____ **Date**_____

**1: How do you rate your <u>confidence</u> that you could get and keep an erection?**

| Without Aid | With Aid (Medications, Pumps, Injections, etc.) | |
|---|---|---|
| ☐ | ☐ | 1. Very low |
| ☐ | ☐ | 2. Low |
| ☐ | ☐ | 3. Moderate |
| ☐ | ☐ | 4. High |
| ☐ | ☐ | 5. Very high |

**2: When you had erections with sexual stimulation, <u>how often</u> were your erections hard enough for penetration (entering your partner)?**

| | | |
|---|---|---|
| ☐ | ☐ | 1. Almost never or never |
| ☐ | ☐ | 2. A few times (much less than half the time) |
| ☐ | ☐ | 3. Sometimes (about half the time) |
| ☐ | ☐ | 4. Most times (much more than half the time) |
| ☐ | ☐ | 5. Almost always or always |

**3: During sexual intercourse, <u>how often</u> were you able to maintain your erection after you had penetrated (entered) your partner?**

| | | |
|---|---|---|
| ☐ | ☐ | 1. Almost never or never |
| ☐ | ☐ | 2. A few times (much less than half the time) |
| ☐ | ☐ | 3. Sometimes (about half the time) |
| ☐ | ☐ | 4. Most times (much more than half the time) |
| ☐ | ☐ | 5. Almost always or always |

**4: During sexual intercourse, <u>how difficult</u> was it to maintain your erection to completion of intercourse?**

| | | |
|---|---|---|
| ☐ | ☐ | 1. Extremely difficult |
| ☐ | ☐ | 2. Very difficult |
| ☐ | ☐ | 3. Difficult |
| ☐ | ☐ | 4. Slightly difficult |
| ☐ | ☐ | 5. Not difficult |

**5: When you attempted sexual intercourse, <u>how often</u> was it satisfactory for you?**

| | | |
|---|---|---|
| ☐ | ☐ | 1. Almost never of never |
| ☐ | ☐ | 2. A few times (much less than half the time) |
| ☐ | ☐ | 3. Sometimes (about half the time) |
| ☐ | ☐ | 4. Most times (much more than half the time) |
| ☐ | ☐ | 5. Almost always or always |

**TOTAL SCORE: Without Aid:**_____**With Aid:** _____

Please check type of aid used:
☐ Pills (Viagra, Levitra, or Cialis) ☐ Muse (Pellets)
☐ Vacuum Device ☐ Injection
☐ Other (please specify):

GAMMA WEST CANCER SERVICES
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# Falls Risk: A Self-Assessment

To find out if you are at risk for falls, answer the questions below

| | Yes | No |
|---|---|---|
| Have you fallen two or more times in the past year? | | |
| Have you Fallen with injury in the past year? | | |
| Do you experience dizziness and/or have trouble keeping your balance? | | |
| Is walking difficult due to muscle weakness, stiff joints, or foot problems? | | |
| Are you on more than three medications? | | |
| Do you have problems with your vision that is not corrected with glasses? | | |
| Do you make frequent or hurried trips to the bathroom? | | |
| Are there fall hazards in your home? I.e.: uneven steps, rugs, poor lighting, slippery floors | | |
| Does the fear of falling reduce your physical or social activity? | | |
| Do you ever feel lonely, depressed, isolated or unable to concentrate? | | |
| Do you consume alcohol more than occasionally? | | |
| Do you use (or have been encouraged to use) a cane or walker? | | |
| Are you over the age of 75? | | |
| Total: | | |

Add the total of the Yes column to determine your risk of falling.

0-5 points = Low Risk  6-8 points = moderate risk  8+ points = High Risk

Patient Name_____ Date_____