COMPREHENSIVE
CANCER CENTERS

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

Comprehensive Cancer Centers of Nevada is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Cancer Centers of Nevada.

Date: _____

Name: _____

Signature: _____

Name of Personal Representative *(if appropriate)*: _____

Signature of Personal Representative *(if appropriate):* _____

Comprehensive Cancer Centers of Nevada Use Only

Date acknowledgment received:)_____ -

OR-

Reason acknowledgment was not obtained: _____

_____

_____

_____

COMPREHENSIVE
CANCER CENTERS

Using and Disclosing Protected Health Information for Involvement in the Individual's Care and Notification Purposes

As per the notice of privacy practices, Comprehensive Cancer Centers must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patients' family member, friends or acquaintances involved in their care.

This document will serve as a written agreement between _____ (patient) and Comprehensive Cancer Centers as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to. It will be the patient's responsibility to update as necessary.

Next of kin:

Name	Phone	Relationship
_____	_____	_____

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes / No Per My Permission – Leave medical information on my answering machine.

I hereby authorize Comprehensive Cancer Centers to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my care. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating), a family member, personal representative or another person responsible for my care, of my location and/or condition.

_____	_____	_____
Patient Signature	SS #	Date

COMPREHENSIVE
CANCER CENTERS

Patient Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Primary Care Physician: _____ Referring Physician: _____

Other physicians: _____

_____

What is the main problem you are here for?

_____

Have you had any of the following diseases, and about how old were you when you had it or it started?

Diseases/Illness	Age	Details
___Diabetes	___	_____
___Kidney Disease	___	_____
___Liver Disease	___	_____
___Rheumatic Fever	___	_____
___Seizures	___	_____
___Asthma/Emphysema/COPD	___	_____
___Heart Disease	___	_____
___Blood Clots	___	_____
___Thyroid Problems	___	_____
___Nerve or Brain Problems	___	_____
___Depression or Anxiety	___	_____
___Blood Problems	___	_____
___Rheumatoid Arthritis	___	_____
___High Blood Pressure	___	_____
___Others	___	_____

Previous Surgeries	Date
_____	_____
_____	_____
_____	_____
_____	_____

Vaccines (please list date)

Tetanus _____ Pneumovax _____ Flu _____ Zostavax _____

Cancer Screening (please list date)

Colonoscopy _____

Mammogram _____

PSA Check _____ Level? _____

Pap smear _____

Please list all of your medications, herbal supplements, vitamins or complimentary/alternative treatments:

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications?

Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy you would like prescriptions called into: _____

Phone#: _____

Social History

Do you smoke: ____yes ____no

Did you smoke in the past? ____yes ____no

Age start _____ Age stop _____

Cigarettes ____ Pack/day _____

Cigars _____ #/day _____

Pipe _____ Pipes/day _____

Do you drink alcohol? ____yes ____no

How much? What type? _____

Did you ever drink alcohol? ____ yes ____ no Date quit? _____

Are you currently: employed retired unemployed on disability

Occupation: _____

Marital Status: single married divorced widowed separated

Children: # of sons _____ ages _____ any illness _____

# of daughters _____ ages _____ any illness _____

Family History

	Alive?/Age	Cause of Death
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
	_____	_____
	_____	_____
Sisters	_____	_____
	_____	_____
	_____	_____

Review of Systems

Constitutional: ____fever ____sweats ____weight loss ____how much?
____pain(rate 1-10)____ ____fatigue(rate1-10)____

Head: ____headache ____dizziness

Ears: ____deafness ____ringing in ears

Eyes: ____pain ____decrease vision ____double vision ____spots before eyes

Nose: ____bloody nose ____nasal obstruction

Throat: ____sore ____blood in mouth ____sore spots ____hoarseness

Chest: ____cough ____cough with blood ____shortness of breath ____pain with breathing

Heart: ___chest pain ____palpitations ____ankle swelling ____difficulty lying down

Abdomen: ____pain ____nausea ____vomiting ____hepatitis ____jaundice ____constipation ____diarrhea ____blood in stool ____black tarry stool

Urinary: ____pain ____bleeding ____incontinence ____difficulty in starting flow

Reproduction: Last menstrual period_____ how many days? ____ heavy Y/N

breast self exam ___yes ___no

number of pregnancies _____ number of live birth____

are you pregnant ___yes ___no

age at onset of periods ____

have you ever used hormones? ___yes ___no

have you ever taken birth control? ___yes ___no

Neurological: ____numbness ____weakness ____trouble walking ___poor coordination

Skin: ____rash ____itching ____moles ____lumps

Hematology: ____abnormal clotting ____abnormal bleeding ____blood disorders

Blood Transfusion Y/N Date: _____ How much? _____units

For office use:

Temp _____ HR _____ RR_____ B/P _____ Height _____(in) Weight _____(lbs)

BSA _____(m2)

Date: _____ RN/MA _____

COMPREHENSIVE
CANCER CENTERS

Cancer Family History Questionnaire

Please complete this form to the best of your ability and bring it to your next scheduled visit with your physician. This information will assist your physician in knowing the cancers that may run in your biological (blood related) family. When you complete the table below, please include your information as well as information for your parents, sisters, brothers, sons, daughters, grandparents, aunts, uncles, and first cousins. Please sign the form.

Date Form Completed: _____ Date of Birth: _____/_____/_____

Print Name: _____Patient's Signature: _____

Cancer Type	Who was/is affected? At what age was the cancer type found? *For Example: Dad, 45 years old Mom, 67 years old Son, 56 years old*
Ovarian	
Breast	
Uterus	
Colon/rectal	
Prostate	

Are there any other cancers that run in your family?

_____

Are you of Ashkenazi Jewish descent? ☐ **YES** ☐ **NO**

Are you of African American descent? ☐ **YES** ☐ **NO**

Have you or anyone in your blood related family had 20 or more lifetime colon polyps? ☐ **YES** ☐ **NO**

Has anyone in your family had cancer genetic testing? _____If yes, explain: _____

Are you concerned about your personal and/or family history of cancer? _____

For Healthcare Provider/Staff completion:

Recommendations: ☐ Refer for Genetic Counseling *(by MD order or physician standing order).*

☐ No Genetic Counseling referral indicated at this time.

COMPREHENSIVE
CANCER CENTERS

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. If you do not have e-mail access, please check the box and sign at the bottom.

_____ _____
Patient Name (First Name, Middle Initial, Last Name) | Date of Birth of Patient

☐ **I do not have e-mail access.** ☐ **I do not want access to the portal.**

Authorized user is:

_____
Authorized User Name (If different from patient)

- ☐ Patient
- ☐ Patient's Guardian (or parent of un-emancipated minor patient)
- ☐ Person authorized to make decisions on behalf of patient (*e.g*. by a medical power of attorney)

_____ _____
Email Address of Patient or Authorized User | Physician's Name

_____ _____
Authorized Signature | Date

_____ _____
Signature of Practice Staff [Confirming user's identity and authority] | Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN_____
Email in PMS_____	iKM Consent_____

COMPREHENSIVE
CANCER CENTERS

Electronic Prescriptions

Comprehensive Cancer Centers of Nevada uses electronic prescriptions to manager your medications.

By utilizing this system, we can automatically send your prescriptions to your pharmacy. You no longer need to take a paper prescription to your pharmacy for non-narcotic medications.

Certain prescriptions cannot be sent electronically due to federal guidelines. In those cases, your physician will give you a paper prescription to take to your pharmacy.

Refill requests will also be managed in the same manner. Please contact your pharmacy directly to request refills on your medications. They will send an electronic notification to your physician's nurse to obtain approval to refill the medication.

In order to effectively send your prescriptions to the correct pharmacy, we need to collect the following information:

Patient Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Or Cross Streets: _____

Pharmacy Phone Number: _____

Thank you and please let us know if you have any questions.