Concussion Evaluation / Patient Information Sheet

(Please Print)

Patient Name: _____ **Date of Injury:** _____ / _____ / _____
Last First Middle I

Date of Birth: _____ / _____ / _____ **Soc. Sec. # :** _____ / _____ / _____ **Sex:** ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other _____

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic **Primary Language**:_____

Home #: _____ **Cell #:** _____ **Work #:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact_____ **Phone:** _____

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: _____ **Relation:** _____

■ **Primary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

■ **Secondary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

PLEASE COMPLETE THIS SECTION IF THIS IS A WORK RELATED INJURY OR AUTO ACCIDENT
(IF NEITHER, SKIP TO NEXT PAGE)

Patient Name: _____

■ Work Related Injuries

Date of Injury: _____ / _____ / _____ **Claim #:** _____

Employer: _____ **County located in:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

Address where Injury Occurred- if different than address above:

City: _____ **State:** _____ **Zip:** _____

Job Title: _____ **Usual Job Duties:** _____

■ Auto Accident

Date of Injury: _____ / _____ / _____ **Claim #:** _____

State where Injury Occurred: _____

Auto Insurance Carrier: _____

Insurance ID # : _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

■ Attorney Information - if Applicable

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Patient Name: _____Date of Injury: _____ / _____ / _____

Describe how the injury occurred:

_____

_____

_____

_____

Were you Hospitalized for this Injury ☐ No ☐ Yes- If yes- What Hospital? _____

If injury occurred at school/school event, what school do you attend? _____

_____

Athletic Trainer Name: _____

Do you have memory of the injury? ☐ Yes ☐ No

Symptoms at the time of the concussion:

☐ Unconscious Episode ☐ Dizziness ☐ Headache

☐ Fogginess ☐ Disorientation

☐ Other: _____

Symptoms after concussion / or at this time:

☐ Balance Impairment ☐ Memory Issues ☐ Vision Problems

☐ Movement Problems ☐ Nausea / Vomiting ☐ Disturbed Sleep

☐ Other: _____

Have you had any treatment for this recent injury? ☐ No ☐ Yes, please describe:

_____

_____

_____

Patient Name: _____

Past Medical History:

Do you or have you had any problems with the following: (Check all that apply)

☐ Alcohol Abuse	☐ Diabetes	☐ Kidney Disease
☐ Arthritis (Osteoarthritis)	☐ Fibromyalgia	☐ Liver Disease
☐ Arthritis (Rheumatoid)	☐ GERD (Reflux)	☐ Stroke/ TIA
☐ Asthma	☐ Heart Disease	☐ Thyroid
☐ Cancer	☐ Hepatitis	☐ Anxiety
☐ Cholesterol	☐ HIV/AIDS	☐ Depression
☐ Drug Abuse	☐ Hypertension	

Past Concussion History: ☐ No ☐ Yes, please describe:

_____

_____

_____

Family History: Please check any diseases/disorders that run in your family. **Do not include yourself**.

	Relative		**Relative**		**Relative**
☐ Motion Sickness	_____	☐ Heart disease	_____	☐ Arthritis	_____
☐ Migraine	_____	☐ Hypertension	_____	☐ Alcohol Abuse	_____
☐ Concussion	_____	☐ Diabetes	_____	☐ Drug Abuse	_____
☐ Cancer	_____	☐ Other	_____		

Social History: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

1. Do you Smoke? ☐ No ☐Yes If yes: Packs/Day____ How many years?_____ / ☐ Quit When?_____
2. Do you drink alcoholic beverages? ☐ No ☐Yes If yes, how much per day?_____ Per week?_____
3. Do you use or have you used street drugs? ☐ No ☐Yes
   If yes, what kind and when? _____

Patient Name: _____

MEDICATION INTAKE SHEET

Please list **all** medications taken on a daily basis, including **vitamins, herbals and over-the-counter** medications. Please list all **medication allergies.** Please list pharmacy name and telephone number.

For Office Use Only: Initial: Ht: _____ Wt: _____ BP:_____ Pulse: _____

Medication Name	Dose/Strength	Times taken per Day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed**:** _____

ALLERGIES: _____

_____

Pharmacy Name _____ **Phone Number**_____

Medication Agreement/Refill Policy

Your treatment plan with NERA may include the care from multiple disciplines, including diagnostic and/ or therapeutic interventions, behavioral medicine, alternative therapies, physical therapy and the prescription use of medications. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us and we need your help to make sure your treatment follows the prescribed guidelines. This agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship.

Please read each statement and sign the agreement below. If you have any questions regarding this information or practice policy regarding the prescribing of controlled substances, please request clarification**.**

You acknowledge that you:

1. Understand that there are potential side effects and interactions involved with taking any medication, including the risk of addiction. Other possible complications include but are not limited to: constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration and reduced sexual function. You may develop a tolerance, and become physically dependent on the medication as well. You understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

2. Understand that opiod medications can cause physical dependence within a few weeks of starting opioid therapy. If you suddenly stop or decrease the medication, you could experience withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24- 48 hour of the last dose. You will not stop these medications without consulting your NERA physician.

3. Agree that you are solely responsible for the safekeeping of your medication and prescriptions used in your treatment. Since the drugs may be hazardous to a person who is not tolerant of their effects, especially children, you must keep them out of reach of such people.

4. **Agree that you will treat your medications and prescriptions as you would any valuable possession.** You understand that NERA does not replace LOST OR STOLEN prescriptions or medications or those destroyed by fire, flood, etc.

5. Agree that you will not share, sell, exchange or otherwise permit others to have access to these medications for any reason.

6. Agree that it is your responsibility to keep yourself and others from harm. This includes driving and the operation of machinery while taking medications that may cause drowsiness or impair cognitive function. If there is any question of impairment of your ability to safely perform these activities, you will not attempt to perform the activity until the side effects have had time to resolve.

7. Understand that if you are pregnant or become pregnant while taking medications, your child could be physically dependent on the opiods and withdrawal can be life threatening for a baby. If a female of childbearing age, you certify that you are not pregnant and you will use appropriate contraceptive measures during the course of treatment with medications. Many medications could harm the fetus or cause birth defects.

8. **Agree to take the medication only and exactly as prescribed by your NERA physician. You may not change your medication dosage amounts without prior authorization from your prescribing physician.**

9. Agree to notify NERA if you experience any adverse effects or dosage problems with your prescribed medications. You may be asked to bring any unused medications to NERA for disposal

10. **Agree that you will not use any illegal substance, (cocaine, heroin, marijuana, etc) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and may result in the termination of your care with NERA.**

11. **Agree that if you receive a prescription for a controlled substance from a NERA provider that you will not accept controlled substance prescriptions from any other physician without your NERA physician's consent**.

Obtaining medications from multiple sources can lead to drug reactions and poor coordination of treatment. If, for some reason, you encounter an emergency situation and are given controlled substances by a health care professional, you agree to report the facts of this matter to your NERA physician and you consent to the disclosure of all personal health information related to this matter**.**

12. **Agree to use only <u>one</u> pharmacy for your pain-related medications**. In the event that circumstances require the use of another pharmacy, you will notify NERA of this immediately and provide them with all pertinent contact information.

13. Agree to allow your NERA physician to send a copy of this agreement to your pharmacy, referring physician and all other physicians involved in your care.

14. **Agree to keep all scheduled appointments. You understand that no medication prescriptions/refills will be given for canceled or no-show appointments.** You understand that if you are 15 minutes late for an appointment time, you will be rescheduled for another appointment and no prescriptions/refills will be given.

15. Agree that you cannot be seen at the office without a scheduled appointment for any reason. NERA physicians do not see "walk-in" patients.

16. Understand that it is not our practice to make changes to your prescriptions by telephone.

17. Understand that each prescription is for a specific number of pills, designed to last a certain amount of time**. Early refills generally will not be given.**

18. Understand that you must call the office <u>two days before</u> your prescription(s) will run out so we have sufficient time to process your refill request. Medical Assistants' phone triage hours are from **9AM- 4:00PM, Monday through Friday** for refill requests and questions. Medical Assistants are assisting the doctors during the day and may not be able to speak with you directly at the time of your call. Please leave detailed information and you will receive a call back before the end of the business day. **Calls after 4:00 PM** will be addressed the next <u>business</u> day. **Calls after 4:00 PM on Friday** will be addressed the following Monday.

19. **Agree not to seek medication/refills after office hours, on the weekend, on holidays or prior to next office visit**.

20. Understand that you can be asked to bring any or all of you prescribed medicines to your office appointment or at a random time for a prescription compliance check (Pill Count)

21. Understand that changing dates, quantity, strength of medicines or altering a prescription in any way is against the law. Forging prescriptions or a physician's signature is also against the law. Dealing with forged, falsified, or altered prescriptions will result in your immediate discharge from NERA. NERA cooperates fully with law enforcement agencies in regards to infractions involving prescription medications.

22. Understand that if the responsible legal authorities have questions regarding your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

23. **Understand that NERA reserves the right to perform a urine drug screen at any time while you are being treated with prescribed, controlled substances**. If the results of the urine drug screen do not reflect medicine prescribed by your physician or you test positive for illegal substances, you understand this may result in the cessation of the prescribing of any controlled substances and you may be discharged from the practice immediately.

24. Understand that the main treatment goal in using pain medications is to improve your ability to function and/or to work and /or reduce pain, In consideration of that goal and the fact that you may be given strong medication to help you reach that goal, you agree to help yourself by following better health habits. This may include exercise, weight control and avoiding the use of nicotine. You agree to comply with the treatment plan as prescribed by your NERA physician.

25. Understand that your medication regimen may be continued for a definitive time period as determined by your NERA physician. Your treatment plan will be reviewed periodically. If there is no significant evidence of improvement or that progress is being made to improve your functioning or quality of life, the regimen may be tapered or possibly discontinued and your care referred back to your primary care physician.

26. Understand that this agreement is important to your physician's ability to treat your pain effectively, and that failure to comply with the agreement may result in the discontinuation of prescribed medication and the possibility of termination of the physician/patient relationship.

27. Understand that inappropriate or abusive behavior or harassment of any NERA staff will not be tolerated. The physicians will determine what actions can be considered harassment on a case-by-case basis and if warranted, you can be discharged from the practice.

28. **Understand that the physicians of NERA may terminate and cancel any prescriptions, and discharge you from the practice if any of the following occurs**:
    - You give, sell, or misuse your pain medication, including but not limited to: taking more medication than prescribed, running out of medication early, obtaining medications at more than one pharmacy,
    - You fail to keep your follow- up appointments,
    - You attempt to obtain pain medication after office hours, on the weekend, on holidays, from any other physician, or any other source,
    - You do not cooperate with requested Pill Counts or Urine screens,
    - Your urine screen shows the presence of medications that your NERA physician is unaware of, the presence of illegal substances, or does not show the presence of medications that your are receiving a prescription for,
    - You are released from the practice for any reason,
    - Any aggressive behavior toward NERA staff or physicians,
    - Any allegations, suspicious information or an investigation is initiated by anyone regarding potential violations of this agreement, is brought to the attention of your NERA physician.

By signing this document you acknowledge that:
- You have thoroughly read, understand and accept all the above provisions.
- You understand that you will receive information from your treating NERA physician regarding the risks and potential benefits of these medications and you should address any concerns regarding your medication regimen with your NERA physician.
- You have received and understand the NERA Prescription Refill Policy.
- You agree to adhere to the terms of this Medication Agreement and the NERA Prescription Refill Policy, knowing that **failure to do may result in termination of treatment with all Northeast Rehab providers**.
- This agreement is in effect for the duration of your treatment.

Your NERA physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis. Lack of strict adherence to any provision of this agreement by your NERA physician in no way invalidates any other provision of this agreement. If at any time you are concerned about your medication or side effects of your medication, please contact our office.

Patient Signature _____ Date _____/_____/_____

Patient Name _____ Date of Birth _____/_____/_____
Please Print

The pharmacy you have selected is: _____ _____
Pharmacy Name Phone

If you change your pharmacy for any reason, you agree to notify this office at the time you receive a prescription.

Reviewed by Physician/Staff Signature _____ Date_____/_____/_____

pennsylvania
DEPARTMENT OF HEALTH

PRESCRIPTION DRUG MONITORING PROGRAM

To prevent prescription drug abuse and protect the health and safety of our community, the Pennsylvania Department of Health collects information on all filled prescriptions for controlled substances. Controlled substances are drugs that have potential for abuse or dependence.

This information helps health care providers safely prescribe controlled substances and helps patients get the treatment they need.

NEED HELP?

If you or someone you care about needs addiction treatment, visit:

▶ **apps.ddap.pa.gov/GetHelpNow**

or call **717-783-8200.**

YOUR RIGHTS

Patients have the right to review and correct the information collected by the Prescription Drug Monitoring Program (PDMP) once per calendar quarter at no cost.

If you would like a copy of your information, complete the form provided on the PDMP website and mail it to the address on the form.

For more information, visit www.doh.pa.gov/PDMP.

Patients can receive a copy of their information more than once per calendar quarter for a fee of $20 per copy. Prescription records will be maintained for seven years. Authorized users of the PDMP system include prescribers, dispensers, the attorney general's office (on behalf of law enforcement), designated commonwealth personnel, and medical examiners or county coroners. Prescription information is confidential and is not subject to the act of Feb. 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.