apm advanced pain medicine

Advanced Pain Medicine

www.advancedpainmedicine.com

Telephone: 724.933.0300 Fax: 724.933.0456

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Clinic Locations:

MAIN OFFICE
7000 Stonewood Drive
Suite 151
Wexford, PA 15090

1300 Oxford Drive
Suite 1D
Bethel Park, PA 15102

911 East Brady Street
Butler, PA 16001

545 Rugh Street
Suite 6000
Greensburg, PA 15601

2566 Haymaker Rd
POB 1, Suite 311
Monroeville, PA 15146

1009 Beaver Grade Rd
Moon Twp, PA 15108

138 Gallery Drive
McMurray, PA 15317

500 Lewis Run Road
West Mifflin, PA 15122

333 State Street
Suite 104A
Erie, PA 16507

500 Market Street
Suite 202
West Bridgewater, PA 15009

What is our process?

When first becoming a patient, a thorough examination is performed and a complete medical history is reviewed. This enables our specialists to confirm or diagnose the patient's particular problem. Next, the physician specialists and clinical staff will develop the treatment plan that will best serve the patient.

The treatment plan may begin with a series of epidural steroid injections, then according to the degree of your pain relief, may proceed with nerve blocks and diagnostic procedures in order to identify the point of origin of the patient's pain. A regimen of pain medication may be included in the treatment plan, which is tailor-made to meet the individual's needs. Monitoring the patient's body's reaction throughout the course of treatment is vital in the diagnosis of the cause of pain, so it is important to adhere to the plan, even if the patient feels the procedures are not helping.

List of Procedures

⇒ **Epidural Steroid Injections**	usually done in a series of 2 or 3
⇒ **Facet Nerve Blocks**	usually done in a series of 2, will do right/left side first, then patient will return for the opposite side
⇒ **Discogram**	done to identify origin of pain, try to reproduce the patient's pain.
⇒ **Rhizotomy**	deaden the nerve causing the patient's pain
⇒ **Spinal Cord Stimulator**	will have a trial first, if successful, will have a permanent placement.
⇒ **Intrathecal Pump**	will have a trial first, if successful, will have a permanent placement

Participating w/ following Health Plans:

Highmark (all products) Medicare United HealthAmerica (all products) BCBS Tricare
UPMC Gateway Cigna
PA Worker's Comp OH Worker's Comp Aetna

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. It will be entered into our system to ensure the best possible care for you.

Patient's Last Name _____ **First** _____ **MI** _____

Sex ☐ Male ☐ Female **Date of Birth:** _____
Name of Primary Care Physician: _____ **Phone # of PCP:** _____
Name of Referring Physician: _____ **Phone # of referring:** _____
Pharmacy Preference (include location): _____ **phone #:** _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction*

Latex Allergy: ☐Yes ☐No

IV Contrast Allergy: ☐Yes ☐No

SURGERIES, HOSPITALIZATIONS AND MEDICAL CONDITIONS. If yes, please list:

SURGERIES: _____

_____

_____

_____

HOSPITALIZATIONS: _____

_____

MEDICAL CONDITIONS: _____

_____

RECENT DIAGNOSTIC TESTS, MRI'S, X-RAY'S, EMG'S (Please indicate when/where these were performed):

_____

_____

Have you ever had any problems with **anesthesia** (being numbed or put to sleep)? □Yes □No
Have you ever been hospitalized for **non-surgical** reasons? □Yes □No
If yes, list reasons for hospitalizations _____

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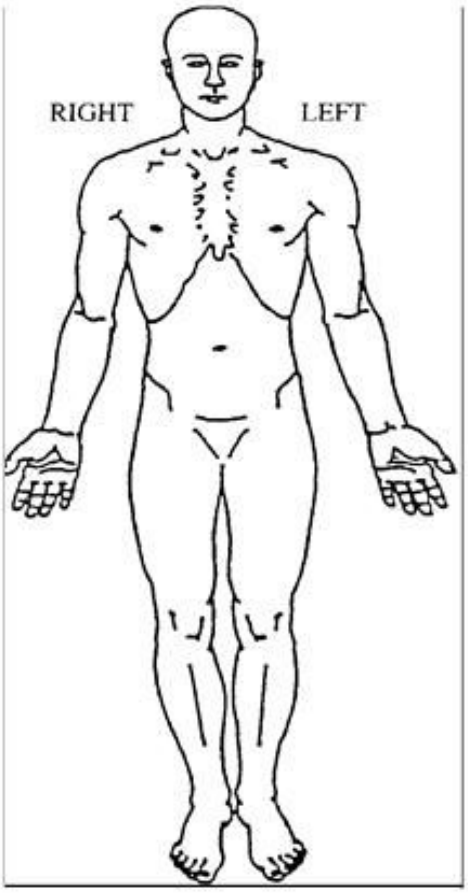
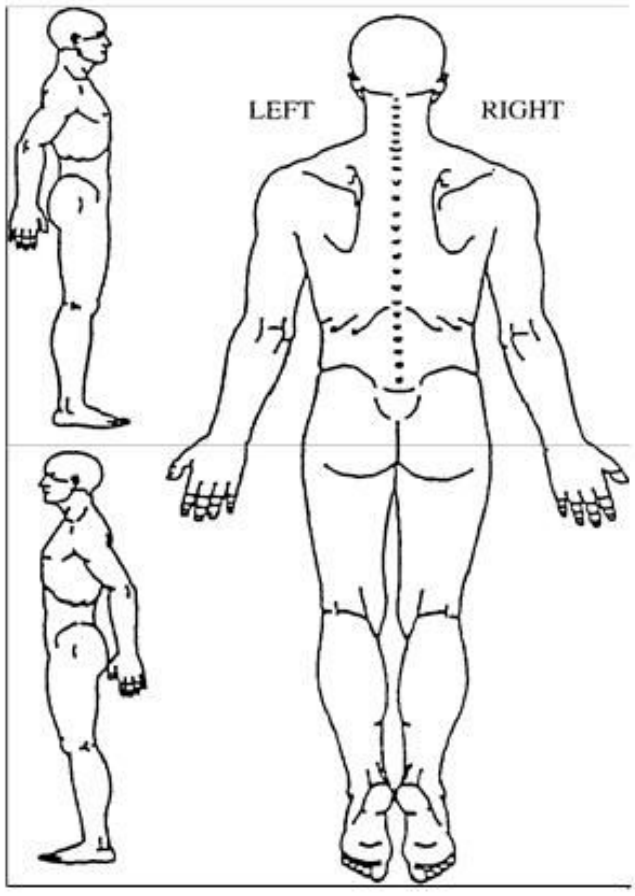
[redacted]





Advanced Pain Medicine

7000 Stonewood Drive, Suite 151, Wexford, PA 15090
Phone: (724) 933-0300 Fax: (724) 993-0456

1. Name: _____

First Middle Initial Last

2. Social Security #:

3. Date of Birth: _____

1. What is the main complaint for which you are seeking treatment at Advanced Pain Medicine?

2. On the diagram, shade in the areas where you feel pain. Put an “X” on the area that hurts the most.

3. How long have you had the pain problem you are currently experiencing (in months and years)?

4. What caused your current pain?

5. Describe the characteristics of your pain (circle each that describes your pain).

Piercing	Throbbing	Numbing
Stabbing	Cramping	Itching
Shooting	Aching	Tingling
Burning	Stinging	None
Grinding	Squeezing	

6. Rate your pain by placing an “X” on the line to best describe your pain at its WORST in the past month.

No Pain _____ Pain as bad as it could be

7. Rate your pain by placing an “X” on the line to best describe your pain at its LEAST in the past month.

No Pain Pain as bad as it could be

8. How often do you have pain?

a. ☐ Constantly (80-100% of the time)
b. ☐ Nearly constantly (50-80% of the time)
c. ☐ Intermittently (25-50% of the time)
d. ☐ Occasionally (less then 25% of the time)

9. What kinds of things make your pain feel better? (example: sitting, sleeping, etc.)

10. What kinds of things make your pain feel worse? (example: standing, lifting, etc.)

11. Please circle all associated symptoms of your pain:

Numbness Incontinence of bowel Cool, pale skin

Weakness Tenderness of affected area Swelling

Urinary Incontinence Pain with only a light touch Redness

Other:_____

12. In general, when is your pain the worst?

a. ☐ Morning b. ☐ Afternoon c. ☐ Evening d. ☐ No Typical Pattern

13. Have you lost or gained any weight during the last two weeks? ☐Yes ☐No

a. ☐ Increased _____lbs. b. ☐ Decreased _____lbs.

14. Would you say that your pain has affected your mood? ☐Yes ☐No

Explain: _____

Do you feel sad? ☐Always ☐Frequently ☐Occasionally ☐Rarely

Do you feel helpless? ☐Always ☐Frequently ☐Occasionally ☐Rarely

Do you feel hopeless? ☐Always ☐Frequently ☐Occasionally ☐Rarely

15. Have you ever had any thoughts of wanting to die? ☐Yes ☐No

Describe_____

16. Do you currently have a plan to harm yourself? ☐Yes ☐No

Describe_____

17. Have you had any panic attacks? ☐Yes ☐No

Describe_____

18. Do you fee irritable or angry due to your pain? ☐Yes ☐No

Describe_____

19. Do you ever act angry or aggressive; for example, breaking objects, hitting other people? ☐Yes ☐No

Describe_____

20. Do you presently have any thoughts of harming or hurting anyone? ☐Yes ☐No

Describe_____

21. Have you ever been treated by a psychiatrist, a psychologist, other mental health professionals? ☐Yes ☐No

Describe_____

22. Did any of the above include in-patient treatment? ☐Yes ☐No

Describe_____

SECTION MUST BE COMPLETED.

1. Please indicate which treatments you have tried in the past. Choose the corresponding number indicating the relieving effect on your pain**: PLEASE INCLUDE THE DATE AND DURATION.**

1 – Worsened Pain 2 – No Relief 3 – Partial Relief 4 – Complete Relief

	DATE		DATE		DATE
___Acupuncture	_____	___Hospital Bed Rest	_____	___SI joint injection	_____
___Biofeedback	_____	___Hypnosis	_____	___Spinal Cord Stimulator	_____
___Chiropractor	_____	___Nerve Block	_____	___TENS (Elect Stim)	_____
___Epidural Steroid Inj.	_____	___Physical Therapy	_____	___Traction	_____
___Exercise	_____	___Psychotherapy	_____	___Facet Rhizotomy	_____
___Hot/Cold Tmts	_____	___Surgery	_____		

2. Please indicate all of the medications you have tried for your current pain complaint. Indicate the amount of relief you experienced with each medication by writing the corresponding number below. Any medication you have not previously tried leave blank.

1 – Worsened Pain 2 – No Relief 3 – Partial Relief 4 – Complete Relief

☐ Anti-Neuropathic	☐ Non-Steroidals	☐ Narcotics	☐ Tranquilizers
___Neurontin (gabapentin)	___Aspirin	___Vicodin	___Ambien
___Lyrica (pregabalin)	___Aleve	___Percocet	___Serax
___desipramine	___Etodolac	___OxyContin	___Valium
___Elavil (amitriptyline)	___Advil (ibuprophen)	___Opana	___Xanax
___Topamax	___Mobic	___Butrans	___Flexeril
___Cymbalta	___Naprosyn	___Morphine	___Soma
___Other:	___Celebrex	___Ultram	___Zanaflex
___Other:	___Nucynta	___Lunesta	
	___Fentanyl Patch	___Doxepin	
	___Suboxone	___Other:	
		___Methadone	
		___Other:	

3. Have any other health care professionals and/or specialists been involved in the evaluation and treatment of your current pain? **If so, please state their name, specialty, and/or their practice name if known.**

Effects of Pain on Lifestyles

Place an “X on the line to describe how pain has interfered with your:

a. Normal Daily Activities
Does not interfere _____ Completely Interferes

b. Ability to Walk
Does not interfere _____ Completely Interferes

c. Ability to Work
Does not interfere _____ Completely Interferes

Goals

Please list your goals of treatment and pain relief while a patient of Advanced Pain Medicine:

Past Medical History

1. Aside from your pain problem, how is your general health? (please check one item)

☐Excellent ☐Minor Health Problems ☐Major Health Problems

2. Have you had any of the following health problems? (please circle all that apply)

Neurologic Disorder	Valvular Heart Disease	Liver Disease/Hepatitis/Cirrhosis
Seizures or Epilepsy	Lung Disease	Diabetes or High Blood Sugar
Transient Ischemic Attack/Stroke	Obstructive Sleep Apnea	Thyroid Disease
Chest Pain	Asthma or Wheezing	Kidney Disease/Kidney Stones
High Blood Pressure	Chronic Cough	Muscle Disease
Heart Attack	Stomach Ulcer	Arthritis
Heart Rhythm Disorder	History of Polyps	Fractures

Blood Disorder	Cancer	Suicidal Tendency
Anemia	Depression	Other:
Blood Clots: Pulmonary/DVT	Mania	

Review of Symptoms

Please circle the symptoms listed below that you have experienced in the past few months.

CONSTITUTIONAL: Fever Chills Weight Change Change in appetite
EYES: Blurred Vision Change in vision Blindness Eye Pain
EARS, NOSE, AND THROAT: Loss of Taste Difficulty Hearing Difficulty Speaking Nosebleeds Difficulty swallowing Ringing in the ears Dental problems Hoarseness
CARDIOVASCULAR: Chest Pain Palpitations Leg Swelling Fainting Leg Pain with walking Irregular Heart Beat Difficulty breathing when lying down
RESPIRATORY: Shortness of Breath Cough Wheezing
GASTROINTESTINAL: Nausea Vomiting Jaundice Stool Incontinence Diarrhea Constipation Abdominal Pain Change in bowel habits Rectal Bleeding Black Stools Heartburn
GENITOURINARY: Blood in the urine Burning upon urination Frequent urination Frequent nighttime urination Urinary incontinence Impotence
MUSCULOSKELETAL: Swelling Muscle Pain Joint Pain Muscle Weakness
SKIN: Rashes Bruising easily Ulcers Excessive hair growth Hair loss Itching Suspicious moles
BREASTS: Pain Discharge Lump
NEUROLOGICAL: Headaches Dizziness Memory Loss Confusion Seizures Fainting Numbness Tingling Weakness
PSYCHIATRIC: Anxiety Depression Difficulty sleeping
ENDOCRINE: Excess thirst Weight change Change in libido
HEMATOLOGIC/LYMPHATIC: Enlarged lymph nodes Bleeding tendency Frequent infections
GYNECOLOGIC: Abnormal periods Vaginal discharge Post-menopausal bleeding

Explain any above circled items here:

Social History

1. Current or previous occupation:_____

2. Present employment status:

☐Full Time ☐Unemployed ☐Leave of Absence ☐Student

☐Part Time ☐Retired ☐Homemaker

If you are working full- or part-time, when did you return to work? (Date):_____

3. What was your last day of work (if not currently working)? _____

4. Would you return to work if you had less pain? ☐Yes ☐No

5. Have you tried to return to work? ☐Yes ☐No

6. In what situation did your present pain originally begin? (Choose one)

☐Accident or Injury at home ☐Accident or injury (other) ☐Following Surgery

☐Accident of Injury at work ☐Related to Illness ☐No apparent reason

7. Are you receiving compensation or disability payments now? ☐Yes ☐No

8. Do you have an application for compensation or disability payments now? ☐Yes ☐No

9. Are you suing because of your pain or injury? ☐Yes ☐No

10. Have you ever brought suit for any reason in the past? ☐Yes ☐No

11. Substance intake per day: (Please indicate how often you use or consume the following)

a. Caffeine (coffee, tea, cola, etc.)_____

b. Nicotine (Cigarettes, cigar, pipe, smokeless tobacco, etc)_____

12. Your present use of alcoholic beverages is (choose one):

☐None ☐Occasionally (less than 1 drink per week) ☐Daily

☐Rarely(less than one drink per month) ☐Regularly (drink 2-3 times per week)

Have you ever made a conscious effort to decrease your drinking? ☐Yes ☐No

Has anyone ever irritated you by suggesting that you decrease your drinking? ☐Yes ☐No

Have you ever felt bad about your drinking? ☐Yes ☐No

13. Have you ever used any of the following drugs? Choose all that apply.

PLEASE INDICATE WHEN LAST USED in the space provided.

☐Marijuana _____ ☐Cocaine _____ ☐Other Street Drugs _____

☐Amphetamines _____ ☐Heroin _____ ☐ None of these

14. Marital Status (choose one):

☐Single ☐Divorced ☐Widowed

☐Married ☐Separated ☐Remarried

15. Number of children:_____

16. Present living situation:

☐Alone ☐With Children ☐With friend

☐With Spouse ☐With Parents ☐With other family members

17. Education (check the highest grade/degree completed):

☐Less than 8th grade ☐Some high school ☐Some college ☐Advanced degree

☐Completed 8th grade ☐High school graduate ☐College graduate

Family Medical History

1. Please list any medical conditions that are present in your family: _____

2. Have any of your family members ever had pain problems? ☐Yes ☐No
If yes, who? _____ What kind of pain? _____

3. Is there any family history of anesthesia or surgical problems? ☐Yes ☐No

If yes, please describe: _____

Signature of Patient: _____ **Date Completed:** _____

If form has been completed by someone *other* than the patient, please print and sign name below:
Name: _____
Signature:_____ Relationship to Patient:_____

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Obstructive Sleep Apnea: SCREENING QUESTIONNAIRE

Patient's Name: _____

Date:_____ DOB: _____ AGE: _____ Gender:

Male Female

Please answer the following questions as they pertain to you in the past month

STOP BANG QUESTIONNAIRE

1. **Do you Snore loudly (louder than talking or loud enough to be heard through closed doors)**? ☐Yes ☐No
2. **Do you often feel Tired, fatigued or sleepy during daytime?** ☐Yes ☐No
3. **Has anyone Observed you stop breathing during your sleep** ☐Yes ☐No
4. **Do you have or are you being treated for high blood Pressure?** ☐Yes ☐No
5. **Is your BMI Body Mass Index more than 26?** ☐Yes ☐No
6. **Age-are you over 50 years old?** ☐Yes ☐No
7. **Is your Neck circumference over 16 inches for females and 17 inches for males?** ☐Yes ☐No
8. **Gender-are you male?** ☐Yes ☐No

Total **Yes** answers: _____

**High risk OSA if "yes" to 3 or more

**Low risk of OSA if "yes" to less than 3 items

EPWORTH SLEEPINESS SCALE

WHAT ARE THE CHANCES THAT YOU WOULD FALL ASLEEP IN THE FOLLOWING SETTINGS?

PLEASE USE THE SCALE LISTED BELOW TO BEST DESCRIBE YORU LEVEL OF SLEEPINESS.

PLACE THE CORRESPONDING NUMBER IN THE BOX NEXT TO THE SITUATION.

0 = NEVER DOZE

1 = SLIGHT CHANCE OF DOZING

2 = MODERATE CHANGE OF DOZING

3 = DEFINATE CHANCE OF DOZING

SITUATION YOU MIGHT GET SLEEPY IN	CHANCE OF DOZING
1. Sitting and reading	
2. Watching T.V.	
3. Sitting, inactive in public place such as church/a meeting/ a theater	
4. As a passenger in car for one hour with no break	
5. Lying down to rest in the afternoon	
6. Sitting and talking to someone	
7. Sitting quietly after lunch without alcohol	
8. As a passenger, stopped in traffic for a few minutes	

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PATIENT FINANCIAL POLICY

Advanced Pain Medicine (APM) is committed to providing you with the best possible care and will be happy to discuss questions regarding our policies, fees or your responsibilities at any time. A clear understanding of the "Patient Financial Policy" is important for the entire scope of your care.

All patients must complete our "Patient Information Form" **before** seeing a provider. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, phone changes etc....)

INSURANCE: As a courtesy we will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. this includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply factual information as necessary.

REGARDING HMO'S, PPO'S AND MANAGED CARE PROGRAMS: It is your responsibility to obtain referral forms required by your particular insurance company. We will do our best to remind you when a referral is due, but ultimately you are required to keep track of the referrals on hand. If you present to the office without a current referral you will be rescheduled. If you are seen without the referral you will be responsible for the bill.

COPAYS: You are expected to pay your co pay prior to seeing your provider. If you are unable to pay, you may be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE: We will not set up payment arrangements, therefore if you do not have coverage you will be required to pay for your service in full on the date of the appointment. We accept credit cards, money orders and cash payments for your initial evaluation. We will not accept PERSONAL CHECKS for the initial evaluation.

REGARDING MEDICARE: Our providers participate with Medicare. We will file all claims with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance you will be responsible for the co-insurance and/or deductible amount following the processing of your claim.

MEDICAL RECORDS/FORM COMPLETION: A charge of $20.00 is due before the forms will be completed. (Disability, FMLA, Physician statements, etc.). There is a patient charge $20.00 to release medical records. If you do have a balance on your account records will not be released until your past balance is paid, along with the $20.00 records release charge.

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WORKERS COMPENSATION: Our office requires verification of your claim prior to the initial visit. You are also to provide us with any other health insurance coverage in case your workers

compensation denies the services. If you do not have health insurance coverage you will be asked to self pay for claims denied by your workers compensation claim.

AUTO LIABILITY: Our office requires verification of the claim prior to the initial visit. You are also required to provide your health insurance coverage. If you do not have health insurance coverage, we will not be able to schedule an appt. In the case that your do have health insurance coverage and it terms you will be responsible to self pay for claims not covered by your auto claim.

COPAYS/DEDUCTIBLES/GUARANTOR RESPONSIBILITY: Our office requires payment in full for any balance not paid by insurance within three months from the date of service. If you are unable to pay our balance in full it is the patient's responsibility to make arrangements with our billing office.

RETURNED CHECKS: There is a $30.00 returned check fee payable in cash or money order.

NO SHOW APPOINTMENTS: You are expected to show for the appointments made for you to adequately provide care. Failure to provide notice (of 24hrs for office visits and 48 hours for procedures) that you will not be keeping your appointment may result in additional fees and or termination from the practice.

I understand I may be charged for any appointments missed without giving 24/48 hours prior to notice. By signing this from I acknowledge that I have read this policy and understand the terms outlined above. Failure to comply with the financial policy of APM may result in suspension of services or dismissal.

Patient Name (Please print) Patient Signature Date

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Phone: 724-933-0300 Fax: 724-933-0456

Authorization for USE/DISCLOSURE of Protected Health Information

I hereby authorize to release information
(Name of facility, entity, or practitioner)

FROM the record of:
Patient Name: _____
Date of Birth: _____ SSN: _____

Release/disclose information **TO**:
ADVANCED PAIN MEDICINE
7000 Stonewood Drive
Wexford, PA 15090

For the specific purpose of:

Continued care _____
Legal _____
Insurance/Provider _____
Personal _____
Other _____

Method of Release/Disclosure:
Verbal only: Copy only: Verbal or copy: _____

Provide **dates of treatment** (approximate, if known):

The information to be released is:

____ Discharge Summary ____ PT, OT, SLP Evaluation ____ Radiology Reports

____ History/Physical Exam ____ Progress Notes ____ Photos, videos, images and films

____ Consults ____ Lab Tests/Exams ____ Psych Diagnostic Interview

____ Operative Report ____ Complete Health Record ____ Other _____

NOTE: Psychotherapy notes are excluded from this authorization, as they require a special authorization for use/disclosure.

Behavioral Health, AIDS or HIV, and Drug and Alcohol related information may be documented within the record indicated above and will be released through this authorization unless otherwise indicated.

Indicate DO NOT RELEASE by checking:

☐ **AIDS/HIV** ☐ **Behavioral Health** ☐ **Drug and Alcohol** **Please INITIAL:**

I_____ hereby give permission to Dr. Nussbaum and/or Dr._____ to submit the findings of my clinical examination treatment plan to Advanced Pain Medicine as part of my coordinated care. I understand this may be a part of my electronic medical record.

Name: _____ **Date:**_____

PLEASE BE CERTAIN TO PROVIDE ALL APPROPRIATE SIGNATURES ON PAGE TWO OF THIS FORM. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING INFORMATION THAT RELATES TO YOUR SIGNING THIS AUTHORIZATION TO USE/DISCLOSE. PLEASE INITIAL WHERE INDICATED.

I **understand** that my authorization is necessary to **obtain or release** my health information and that I may revoke this authorization at any time, **in writing**, except to the extent that Advanced Pain Medicine may have already relied upon it in making a use or disclosure. My written revocation will become effective upon Advanced Pain Medicine having knowledge of it. If I have provided this authorization to obtain insurance coverage, I may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under my insurance policy. I understand that to revoke this authorization, I must send my written request to Advanced Pain Medicine.

This authorization is **limited** to the **purpose** and to the person listed above and will be in effect for **6 months** after the date of my signature, unless otherwise specified.
This authorization will expire on the following date:
Or when the following event occurs

I understand that information released by Advanced Pain Medicine under this authorization may be re-disclosed by the receiving party, and therefore Advanced Pain Medicine and its

employees have no responsibility or liability as a result of any re-disclosure; as such, the released information is no longer protected by the Privacy Rule.

I understand that Advanced Pain Medicine cannot make me sign this authorization as a condition to receive treatment. **I understand** that I am entitled to a completed copy of the Authorization for Use/Disclosure form.

PLEASE INITIAL TO CONFIRM THAT YOU HAVE READ THE ABOVE AND FULLY UNDERSTAND THE CONTENT.
Patient/Patient representative Initials: X

X **X**
Date of Patient Signature Patient Signature
(My signature confirms my understanding of the intended use of this authorization)

Date of Witness Signature Witness Signature

VERBAL AUTHORIZATION: (Only applicable when patient is physically unable to sign this form. Not applicable to HIV, Drug and Alcohol, and Behavioral Health Related Information.) I confirm that the patient understood the nature of this release and freely gave his/her verbal authorization. (2 witnesses are required)

Date Signature of Witness #1 Obtaining Verbal Order

Date Signature of Witness #2 Obtaining Verbal Order

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Advanced Pain Medicine

Mark R. LoDico, M.D.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me. I understand that information that Advanced Pain Medicine acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THE NOTICE OF PRIVACY PRACTICES AND THAT I UNDERSTAND ITS CONTENTS.

Patient Name (printed) Date

Patient Signature Date

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Request for Confidential Communications

I hereby request the following restriction(s) to confidential communications. I understand that Advanced Pain Medicine will accommodate all reasonable requests, but is not required to agree to all of the terms of this request. Further, I understand that this request will not be honored until a decision to accept or deny this request has been made.

Describe how or where we may contact you about your medical treatment: (include telephone numbers, names of contacts, addresses, what information may be left on voice mail, or any other relevant information as appropriate).

Name:

Relationship Spouse Child Sibling Other

Home Phone: _ Cell

Phone:

What information may be left on voice mail?

Restrictions:

Date

Signature of Patient

or Patient

Representative Print

Name

Relationship to Patient, if Other Than Patient