REFERRAL & RECORDS POLICY

Effective immediately it will be the policy of Neurology Associates of Stony Brook, U.F.P.C. that if you require a referral for your visit you must present it at the time of your service or your appointment will be rescheduled. This includes paper referrals and/or your referrals that can be retrieved on line. Please provide your paper referral and/or your referral number printed off line to our front desk staff.

Please be advised that if you are in need of multiple pages of your medical record that there is a fee and a records release will need to be signed. Please allow 7-10 business days for this process to be completed. Multiple pages of a medical record will not be produced at the front desk of the outpatient office.

Thank you for your understanding with these matters.

Acknowledgement of policies:

Patient / Guardian Signature: ______________________________________________________________

Date: ________________________________

Patient Name: ________________________________

(print)
Ambulatory Progress Note

Pain Management

Date: ___________________

1) Do you have any pain?  ❑ No (please skip to question 4)  ❑ Yes

2) Please describe the quality/location/duration: _______________________________________

3) Measure used to alleviate pain: ______________________________________________________

Intensity Scale: 1  2  3  4  5  6  7  8  9  10

Follow-up:  ❑ Given Pain Brochure  ❑ Referral To: __________________________  ❑ Other: (see progress note)

Comments: ____________________________________________________________________________

Patient Family Education

❑ None this encounter

This form may not reflect all teaching provided. See also Progress notes of individual disciplines.

INITIAL LEARNING NEEDS ASSESSMENT.

4) Do you prefer to learn by:  ❑ Seeing (pictures/video tape, written)  ❑ Hearing (audiotape, verbal cues)
   ❑ Doing (hands on)

5) Preferred Language:  ❑ English  ❑ Other  ❑ Needs Interpreter

6) Are there any cultural/spiritual/religious practices you would like us to know about:  ❑ No  ❑ Yes

Please List: ___________________________________________________________________________

7) Do you have barriers to learning?

   Physical:  ❑ Yes  ❑ No  Vision:  ❑ Yes  ❑ No  Hearing:  ❑ Yes  ❑ No

   Emotional:  ❑ Yes  ❑ No  Financial:  ❑ Yes  ❑ No  Cognitive:  ❑ Yes  ❑ No

Teaching Topic  Person Taught  Eval. Code#

❑ Nutrition / Diet ___________________________________________________________          __________________

❑ Use of Medications _________________________________________________________          __________________

❑ Food / Drug Interactions ___________________________________________________          __________________

❑ Use of Equipment ___________________________________________________________          __________________

❑ Rehab Techniques ___________________________________________________________          __________________

❑ Access Community Resources _______________________________________________          __________________

❑ Advance Directives _________________________________________________________          __________________

❑ Other ______________________________________________________________________          __________________

Evaluation and readiness codes:

1 = Understands and/or perform return demonstration.

2 = Needs further instruction.

3 = Unable to retain information or return demonstration.

4 = Not ready to learn / no interest.

5 = Understands information compliance questionable.

6 = Offered and Refused.

Forms / Education given:

Signature / Title: __________________________  ID#: _______________ Date: _________ Time: ________
Ambulatory Care Consent Form

Patient Name: __________________________________________  Date of Birth: ________________________  

MRN: __________________________________________  ENC#: __________________________________________  

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff.

______________________________________________________________________________________________________
Signature of Patient or Patient Representative
______________________________________________________________________________________________________
Print Name of Patient or Personal Representative
______________________________________________________________________________________________________
Relationship, if signed by person other than Patient
______________________________________________________________________________________________________
Date
______________________________________________________________________________________________________
Description of Personal Representative’s Authority
Patient Name: ___________________________________________ Date of Birth: ________________________

MRN: __________________________________________ ENC#: __________________________________________

By signing below I acknowledge that I have been provided a copy of the SBOHCA Joint Notice of Privacy Practices (Notice) and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

______________________________________________________________________________________________________

Signature of Patient or Patient Representative

______________________________________________________________________________________________________

Print Name of Patient or Personal Representative

______________________________________________________________________________________________________

Relationship, if signed by person other than Patient

______________________________________________________________________________________________________

Date

______________________________________________________________________________________________________

Description of Personal Representative’s Authority
Name: ____________________________________________

1) Do you snore on most nights (more than 3 times a week)?
   □ Yes  □ No

2) Do you, or have you been told, that you stop breathing while you are sleeping?
   □ Yes  □ No

3) Do you wake suddenly during the night?
   □ Yes  □ No

4) Do you suddenly wake up gasping for air?
   □ Yes  □ No

5) Do you wake up in the morning feeling tired?
   □ Yes  □ No

6) Do you wake up in the morning with a headache?
   □ Yes  □ No

Please check any of the following you have:

□ High Blood Pressure
□ Heart Disease
□ Stroke
□ Insomnia
□ Frequent Urination at Night (nocturia)
□ Diabetes
□ Depression
□ Overweight

Are you currently using a CPAP?
   □ Yes  □ No

If yes, how long? ________________________________
**Adult Outpatient History Questionnaire**

**Part 1**

**INSTRUCTIONS:** Please print the requested information or place a check mark “✓” where appropriate. **DO NOT** write in the shaded area.

### Past Medical History

- Have you ever been hospitalized?  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Have you had any serious injuries/broken bones?  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Have you ever received a blood transfusion?  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

### Immunization History

- Hepatitis B  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

- Influenza (flu)  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

- Measles  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

- Mumps  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

- Pneumococcal (pneumonia)  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

- Polio  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

- Rubella  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

- Tetanus/Diphtheria (past 10 yrs)  
  - [ ] Unknown  
  - [ ] No  
  - [ ] Yes  
  - (year _____)

### Have you ever had any of the following?

- Alcohol/drug abuse  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Arthritis  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Asthma  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Colon problems  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Coronary disease  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Depression  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Diabetes  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Endocrine disorder  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Heart attack  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- High blood pressure  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- High cholesterol  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Infectious disease  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Kidney problems  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Lung problems  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Lupus  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Lyme Disease  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Memory loss  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Migraine  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Other  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Psychiatric illness  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Seizure  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Stomach problem  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Stroke/TIA  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Thyroid disease  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

- Tuberculosis  
  - [ ] No  
  - [ ] Yes  
  - _Describe____________________________

---

**Resident Initials:** _______________  **Date:** _______________

**Attending Physician Initials:** _______________  **Date:** _______________

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**Medical Team Use Only**
## Adult Outpatient History Questionnaire
### Part 2

**Review of Systems:**
*Have you ever had a problem related to any of the following areas?*

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>No</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergic/Immunological</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• seasonal allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• immune disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• chest pain, palpitations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• fainting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Constitutional</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• fever, weight loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ears/Nose/Mouth/Throat</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Endocrine (thyroid)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eyes (glaucoma, cataracts)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• blood in stool, nausea, vomit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GU</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• pain with urination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• blood in urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• sexual dysfunction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hematological/Lymphatic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• bruising, lymph nodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• muscle aches, joint pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neurologic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• dizziness/spinning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• double vision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• headache</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• hearing loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• incoordination</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• loss of vision</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• memory loss</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• numbness/tingling</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• ringing in the ears</td>
<td></td>
<td></td>
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<tr>
<td>• sleep disturbances</td>
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<tr>
<td>• slurred speech</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• weakness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Psychiatric</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• shortness of breath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• wheezing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skin/Breast</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• rash, lumps, bumps</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reviewed and Annotated by

Resident Signature / ID#: ___________________________ Date: ____________________

Attending Physician Signature / ID#: ___________________________ Date: ____________________
Adult Outpatient History Questionnaire
Part 3

Do you have allergies (including medications)?

- [ ] No
- [ ] Yes
Describe______________________________

What medications are you currently taking?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Social History:

- How many years of school have you completed? ________ Where were you born? ________ Raised? ________

Employment Status:

- [ ] Retired
- [ ] Unemployed
- [ ] Homemaker
- [ ] Employed (describe) ___________________

Have you traveled to any unusual places?

- [ ] No
- [ ] Yes
Describe: __________________________________________

Marital Status:

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed
- [ ] Children: _____________________________

Have you ever used the following substances?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Current Use?</th>
<th>Previous Use?</th>
<th>Type/Amount/Frequency</th>
<th># of years</th>
<th>Year Stopped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (beer/wine/liquor)</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No [ ] Yes</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Caffeine (coffee/tea/soda)</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No [ ] Yes</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Illicit Substances</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No [ ] Yes</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (toxins/exposure)</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No [ ] Yes</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Tobacco (cigarettes/cigars)</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No [ ] Yes</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Family History:

- [ ] No
- [ ] Yes (if medical history of blood relatives known, describe below)

Father:

- [ ] Alive, Age: ________
- [ ] Deceased, Cause of Death: _______________________

Mother:

- [ ] Alive, Age: ________
- [ ] Deceased, Cause of Death: _______________________

Please List any illnesses in the following family members:

- Father: __________________________________________
- Mother: __________________________________________
- Grandparents: _____________________________________
- Sisters: __________________________________________
- Brothers: _________________________________________
- Children: _________________________________________
- Other: ___________________________________________________________________

Resident Initials: _______________ Date: _______________
Attending Physician Initials: _______________ Date: _______________
## Learning Needs Assessment

Do any of the following apply for you?

- [ ] Impaired Vision
- [ ] Impaired Hearing
- [ ] Impaired or Speaking Problems
- [ ] Pain
- [ ] Concerns about your illness
- [ ] None of the above

What is your primary language? ________________________________

Do you have difficulty understanding English?  
- [ ] Yes  
- [ ] No

Can you read English?  
- [ ] Yes  
- [ ] No

Is there anything about your beliefs or culture that would be important for us to know to provide you health care?  
- [ ] Yes  
- [ ] No, If Yes, what? ____________________________________
  
  ____________________________________________________________________________________
  ____________________________________________________________________________________
  ____________________________________________________________________________________

**Learning Preference:**

How do you prefer to learn?

- [ ] Reading  
- [ ] Person explaining to me  
- [ ] Seeing pictures

Is there anyone you would like to have with you during your teaching?  
- [ ] Yes  
- [ ] No, If yes, whom? ______________________________________________________________________

<table>
<thead>
<tr>
<th>Patient / Designee Signature: ____________________________</th>
<th>Date: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner Signature: ________________________________</td>
<td>ID#: __________</td>
</tr>
</tbody>
</table>