Stony Brook Medicine

School of Medicine
Department of Neurology
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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)

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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: _____

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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

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Stony Brook Organized Care Arrangement (SBOHCA) Ambulatory Care Acknowledgement Form

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

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Sleep Disorder Assessment

Name: _____

1) Do you snore on most nights (more then 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? _____

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Affix Patient Sticker Here
If other than patient, please give name:

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_____

Medical Team Use Only

Resident Initials: _____ Date: _____
Attending Physician Initials: _____ Date: _____

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Affix Patient Sticker Here
If other than patient, please give name:

Adult Outpatient History Questionnaire
Part 2

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

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

Medical Team Use Only

Reviewed and Annotated by
Resident Signature / ID#: _____ Date: _____
Attending Physician Signature / ID#: _____ Date: _____

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Affix Patient Sticker Here
If other than patient, please give name:
_____

Adult Outpatient History Questionnaire
Part 3

Do you have allergies (including medications)? ❑ No ❑ Yes Describe_____

What medications are you currently taking?

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

Medical Team Use Only

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? _____

Are you disabled? ❑ No ❑ Yes Describe: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Children: _____

Have you ever used the following substances?

Substance	Current Use?	Previous Use?	Type/Amount/Frequency	# of years	Year Stopped
Alcohol *(beer/wine/liquor)*	❑ No ❑ Yes	❑ No ❑ Yes	_____	_____	_____
Caffeine *(coffee/tea/soda)*	❑ No ❑ Yes	❑ No ❑ Yes	_____	_____	_____
Illicit Substances *(recreational/street drugs)*	❑ No ❑ Yes	❑ No ❑ Yes	_____	_____	_____
Other *(toxins/exposure)*	❑ No ❑ Yes	❑ No ❑ Yes	_____	_____	_____
Tobacco *(cigarettes/cigars)*	❑ No ❑ Yes	❑ No ❑ Yes	_____	_____	_____

Family History:

Are your adopted? ❑ 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: _____

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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? _____

Patient / Designee Signature: _____ Date: _____

Practitioner Signature: _____ ID#: _____ Date: _____

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