New Hampshire Oncology-Hematology PA

Patient Demographics

General Information

Name:		DOB:	☐Male ☐Female
SS#:	Marital Status:	Ethnicity:	Race:
Address:		City:	
State:	Zip Code:	Employer:	
Home Phone:	Cell Phone:	Email address:	
Referring MD:		PCP:	
Living Will: ☐Yes ☐NO	DNR: ☐Yes ☐NO	DPOA: ☐Yes ☐NO	

Insurance Information

Primary Insurance:		
Policy Number:	Group Number:	
Policy Holder:	Relationship:	Policy Holder DOB:
Prescription Coverage Carrier:		

Secondary Insurance:	
Policy Number	Group Number:
Policy Holder:	Relationship:

Emergency Contact #1 □ **We may speak to this person about your medical care**

Name:	
Relationship:	Phone:

Emergency Contact #2 □ **We may speak to this person about your medical care**

Name:	
Relationship:	Phone:

Pharmacy Information:

Preferred Pharmacy		
City	State	Zip
Phone:		

NEW HAMPSHIRE ONCOLOGY-HEMATOLOGY PA

PATIENT'S LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:

TODAY'S DATE:	NAME OF PHARMACY:	PHARMACY PHONE NUMBER:

MEDICATION LIST

MEDICATION	START DATE (At least year)	DOSE AND INSTRUCTIONS	REASON FOR TAKING	PRESCRIBING DOCTOR
Example: Aspirin	*9/15/2004*	*81 mg daily*	*Cardiac health*	*Dr. Jane Doe*

****PLEASE BRING ALL MEDICATION CONTAINERS WITH YOU TO YOUR FIRST VISIT.**

Revised 07/2013

NCCN Guidelines Version 1.2022
Distress Management

NCCN Guidelines Index
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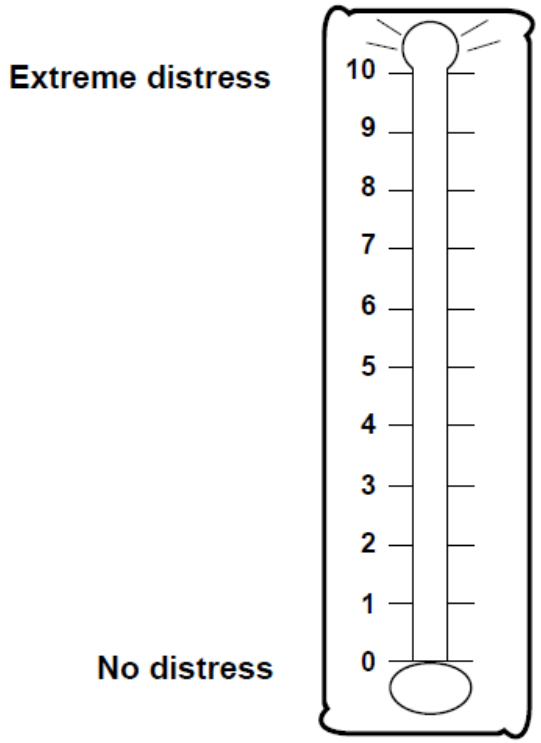
NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.



PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns
- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns
- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns
- ❑ Relationship with spouse or partner
- ❑ Relationship with children
- ❑ Relationship with family members
- ❑ Relationship with friends or coworkers
- ❑ Communication with health care team
- ❑ Ability to have children

Practical Concerns
- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Work
- ❑ School
- ❑ Housing
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns
- ❑ Sense of meaning or purpose
- ❑ Changes in faith or beliefs
- ❑ Death, dying or afterlife
- ❑ Conflict between beliefs and cancer treatments
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns:

_____

_____

_____

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

New Hampshire Oncology-Hematology PA

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. I understand I have the opportunity to ask any questions regarding the privacy practices at NHOH.

_____ _____

Please ***print*** your name Please ***sign*** your name

DOB: _____ OR

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Office Use Only

As the Financial Counselor, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____

Signature & Date