Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRICS

Patient Name: _____ Date of Birth _____ Date: _____
Gender Identity (Optional) _____
Please answer the following questions so that we can better meet your needs.

DEMOGRAPHICS

Referring Physician: _____ Phone: _____
Practice Name: _____
Address: _____
Primary Care Physician: _____ Phone: _____
Address: _____
Other Providers: _____ Phone: _____
Address: _____
Other Providers: _____ Phone: _____
Address: _____
Social Security #: _____ Date of Birth *(mm/dd/yyyy):* _____
What is your current: Height *(feet, inches):* _____ Weight *(lbs.):* _____ BMI: _____ (office use)
Duration of Obesity: years: _____ Maximum Weight: _____ lbs. Age: _____ years
Have you had any prior Gastric Surgery (e.g. gastric bypass)? *(check one)* ☐ YES ☐ NO
If "YES" 1) What was the procedure? _____
2) When was the procedure performed? _____

ALLERGIES

❑ No Known Allergies
List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

❑ Not Taking Any Medications
List any medications you are taking, with dose and how often. Use the back of form for additional medication.

Medication Name:	**Dose:**	**How often?**	**Reason for taking?**

List any Vitamins, Supplements and Over the Counter Medicines

1.	**4.**
2.	**5.**
3.	**6.**

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRICS

Patient Name: _____ Date of Birth _____

PERSONAL / SOCIAL HISTORY

Occupation: _____

Tobacco Use: ☐ YES ☐ NO *If "yes", specify frequency* _____

E-Cigarettes: ☐ YES ☐ NO *If "yes", does it contain Nicotine?* _____

Alcohol Use: ☐ YES ☐ NO *If "yes", specify frequency* _____

Illegal Substances: ☐ YES ☐ NO *If "yes", specify frequency* _____

Medical Marijuana: ☐ YES ☐ NO *If "yes", specify frequency* _____

Marital Status: *(married/single):* _____ Number of Children: _____

Children Overweight: ☐ YES ☐ NO Family Support for Weight Loss: ☐ YES ☐ NO

EXERCISE HISTORY

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Average total hours per week of exercise:	_____	_____	_____	_____	_____	_____	_____

Exercise preferences *(e.g., walking, running, tennis, swimming):* _____

Barriers to exercise *(e.g., time, pain, fatigue, lack of interest):* _____

Have you had weight related injuries? ☐ YES ☐ NO

If yes, please describe: _____

Can you walk unassisted? ☐ YES ☐ NO

If No, what do you use for assistance? _____

Do you use any kind of fitness tracking device? ☐ YES ☐ NO

If so, what kind? _____

DIET HISTORY

Eating habits: *(Please fill in your typical dietary intake (all foods/beverages) in a 24-hour period):*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ *Beverages:* _____

Who buys the groceries? _____ How much do you spend a week on groceries? **$** _____

Do you read food ingredient and/or nutrition labels? ☐ YES ☐ NO

How many restaurant meals per week? _____

List Specific Food Cravings: _____

_____

Emotional Eating: *(eating in response to stress/anxiety, anger…please specify):* _____

_____

_____

(Please check "YES" or "NO")	YES	NO
Binge-Eating Disorder:		
Eat more food than others in a 2-hour period	☐	☐
Unable to stop eating or unable to control what or how much is eaten	☐	☐
Eat rapidly	☐	☐
Eat until stuffed	☐	☐
Eat when NOT hungry	☐	☐
Eat alone because embarrassed to eat amount in front of others	☐	☐
Other (candy)	☐	☐
Frequency (_____ days/week)	☐	☐

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NEW PATIENT MEDICAL HISTORY - BARIATRICS

Patient Name: _____ Date of Birth _____

(Please check "YES" or "NO")	YES	NO
Compensatory Behavior:		
Purge	☐	☐
Fast	☐	☐
Laxatives	☐	☐
Excessive exercise	☐	☐

Prior Dieting Methods: *Duration & total weight loss (*Please check off and fill in all the dieting methods you have tried.)*

	Time on program *(months)*	Weight lost *(pounds)*	Weight loss maintained *(months)*
Self-directed			
☐ Reducing portions			
☐ Decreasing snacks			
☐ Decrease sweets			
☐ Exercise			
☐ Other _____			
Diets			
☐ Atkins			
☐ Carbohydrates			
☐ Cabbage Soup			
☐ Other _____			
Group			
☐ Weight Watchers			
☐ Overeaters			
☐ Jenny Craig			
☐ Other _____			
RX (Physician supervised medication)			
☐ Meridia			
☐ Xenical			
☐ Phen-fen			
☐ Other _____			
Surgery			
☐ Stapling			
☐ Vertical Banded Gastroplasty			
☐ Banded			
☐ Gastroplasty			
☐ Roux-N-Y			
☐ Sleeve			
☐ Doudenal Switch			
☐ Other _____			
Other			
☐ SlimFast			
☐ Other _____			
☐ Other _____			

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(01/2019)

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRICS

Patient Name: _____ Date of Birth _____

MEDICAL HISTORY

(Please check "YES" or "NO")	YES	NO	Onset, duration / Please explain
Obesity-Related Diseases			
Type II Diabetes	☐	☐	_____
Complications of diabetes (kidney disease, retinal disease, peripheral neuropathy, etc)	☐	☐	_____
Hypertension	☐	☐	_____
Joint Pain ./ Disability Level	☐	☐	_____
Heart Disease	☐	☐	_____
Stroke	☐	☐	_____
Asthma	☐	☐	_____
COPD	☐	☐	_____
Sleep Apnea (Dx. By MD) (CPAP/BiPAP)	☐	☐	_____
GERD (heartburn)	☐	☐	_____
Elevated Cholesterol/Triglycerides	☐	☐	_____
Menstrual Irregularity	☐	☐	_____
Depression/Anxiety (Current Treatment)	☐	☐	_____
DVT/Pulmonary Embolism	☐	☐	_____
Fatty Liver Disease	☐	☐	_____
Polycystic Ovarian Syndrome	☐	☐	_____
Kidney Disease	☐	☐	_____
Other	☐	☐	_____
Past Medical History			
Glaucoma	☐	☐	_____
Cancer	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other	☐	☐	_____
Women:			
When was your last mammogram?		Date:	_____
When was your last Pap Smear?		Date:	_____
Have you ever had a colonoscopy?	☐	☐	_____
Men:			
Have you had a prostate exam?	☐	☐	_____
Have you ever had a colonoscopy?	☐	☐	_____
Surgery:	☐	☐	_____
Surgery 1 _____		Date:	_____
Surgery 2 _____		Date:	_____
Surgery 3 _____		Date:	_____
Family History			
Obesity	☐	☐	_____
Hypertension	☐	☐	_____
Type II Diabetes	☐	☐	_____
Coronary Artery Disease	☐	☐	_____
DVT/Pulmonary Embolism	☐	☐	_____
Cancer	☐	☐	_____
Other: _____	☐	☐	_____
Other: _____	☐	☐	_____
Other: _____	☐	☐	_____

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Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRICS

Patient Name: _____ Date of Birth _____

REVIEW OF SYSTEMS

In the **last thirty days,** have you experienced any of the following:

CONSTITUTIONAL			GASTROINTESTINAL			PSYCHIATRIC		
Chills	Yes	No	Abdominal pain	Yes	No	Anxiety	Yes	No
Fatigue/Weakness	Yes	No	Black tarry stools	Yes	No	Depression	Yes	No
Fever	Yes	No	Constipation	Yes	No	Panic attacks	Yes	No
Night sweats	Yes	No	Pain with bowel movement	Yes	No	Insomnia	Yes	No
Weight gain	Yes	No	Diarrhea	Yes	No			
Weight loss	Yes	No	Heartburn/GERD	Yes	No	**SKIN**		
			Loss of appetite	Yes	No	Contact allergy	Yes	No
HEENT			Nausea	Yes	No	Itchy skin	Yes	No
Headaches	Yes	No	Vomiting	Yes	No	Poor wound healing	Yes	No
Blurred/Double vision	Yes	No				Rash	Yes	No
Eye drainage	Yes	No	**GENITOURINARY**			Skin infections/sores	Yes	No
Eye pain	Yes	No	Frequent urination	Yes	No			
Vision loss/Changes	Yes	No	Urinary incontinence	Yes	No	**MUSCULOSKELETAL**		
Ear pain	Yes	No	Pain with urination	Yes	No	Back pain	Yes	No
Ear drainage	Yes	No	Blood in urine	Yes	No	Neck pain	Yes	No
Hearing Loss	Yes	No	Trouble starting or stopping urine	Yes	No	Foot/Ankle pain	Yes	No
Buzzing/Ringing in ears	Yes	No	**Female**			Neuropathy of the feet	Yes	No
Sinus problems	Yes	No	Heavy periods	Yes	No	Knee pain	Yes	No
Nasal drainage	Yes	No	Painful periods	Yes	No	Hip pain	Yes	No
Difficulty swallowing	Yes	No	Vaginal discharge	Yes	No	Joint pain	Yes	No
Sore throat/Hoarseness	Yes	No	Pain with intercourse	Yes	No	Joint swelling	Yes	No
			Male			Muscle weakness	Yes	No
RESPIRATORY			Penile discharge	Yes	No			
Cough	Yes	No	Painful erection	Yes	No	**HEMATOLOGIC**		
Shortness of breath	Yes	No				Bleeding tendencies	Yes	No
TB exposure	Yes	No	**METABOLIC/ENDOCRINE**			Blood clots	Yes	No
Wheezing	Yes	No	Cold intolerance	Yes	No	Easy bruising	Yes	No
			Heat intolerance	Yes	No			
CARDIOVASCULAR			Excessive hunger	Yes	No	**IMMUNOLOGICAL**		
Chest pain	Yes	No	Excessive thirst	Yes	No	Environmental allergies	Yes	No
Heart murmur	Yes	No	Hair loss	Yes	No	Food allergies	Yes	No
Irregular heartbeat	Yes	No	Brittle hair	Yes	No	Seasonal allergies	Yes	No
Palpitations	Yes	No	Brittle nails	Yes	No			
Calf pain with walking	Yes	No						
Leg swelling	Yes	No	**NEUROLOGICAL**					
Feeling Cold or Numbness in extremities	Yes	No	Difficulty walking	Yes	No			
Pain in Arms	Yes	No	Dizziness	Yes	No			
			Poor coordination	Yes	No			
			Memory loss	Yes	No			
			Seizures	Yes	No			
			Tremors	Yes	No			
			Falls	Yes	No			

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Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Patient Name: _____ Date of Birth: _____ Date: _____

Gender Identity (Optional) _____

Please answer the following questions so that we can better meet your needs.

What is bothering you most about your weight? _____

What has caused or triggered weight gain in the past? _____

	Patient Measurement (Please Complete)		Age	Weight
Height		**Birth Weight**		
Initial Body Weight		**After Undergoing Puberty**		
Ideal Body Weight		**High School Graduation**		
Excess Body Weight				
Target Weight		**Lowest Weight in Past 5 Years**		
Body Frame (circle one) Small Medium Large		**Highest Weight in Past 5 Years**		

Energy Patterns

(Please check the answer that applies)

What is your energy level in the morning: ❑ Very Low ❑ Low ❑ Moderate ❑ High ❑ Very High

What is your energy level in the evening: ❑ Very Low ❑ Low ❑ Moderate ❑ High ❑ Very High

Do you work the afternoon or evening shift at work? ❑ YES ❑ NO

Do you shift from days to nights? ❑ YES ❑ NO

Do you consider yourself a morning person (Lark) or an evening person (Owl)? _____

Dietary History

Please give us an idea of your eating habits and patterns:

General Food Questions

Who does the majority of the cooking? _____

Is your home cooked food of a particular ethnic influence? (If so, please check)

❑ Latino ❑ Middle Eastern ❑ East Indian ❑ Kosher ❑ Asian ❑ African ❑ Other

Do you get food through WIC or Food Assistance? ❑ YES ❑ NO

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Patient Name: _____ Date of Birth: _____

Dietary History (continued)

Please give us an idea of your personal eating patterns:

Personal Eating Habits

How much processed food do you eat? ❑ Everyday ❑ Seldom ❑ Rarely ❑ Never
Do you buy your fruits and vegetables at a farmers market? ❑ YES ❑ NO
Do you get coffee drinks in the morning? ❑ YES ❑ NO
If so, what do you add to your coffee (ex: flavored creamer, sugar, sugar substitutes, etc.) _____
Do you drink sugar-sweetened beverages like soda or sports drinks? ❑ YES ❑ NO
If so, what type? _____ How many ounces per day? _____

Social Eating

Describe the last time you got together with friends? _____
_____
Who prepared the food? _____
What did you eat? _____

Was there any exercise involved? ❑ YES ❑ NO

Lifestyle Analysis

These questions give us an idea of what lifestyle issues are important to you and may be related to weight.
Specific question about *alcohol* use (the CAGE review):

Do you ever feel the need to **Cut** down? ❑ YES ❑ NO
Have you ever felt **Annoyed** by criticism of drinking? ❑ YES ❑ NO
Have you ever had **Guilty** Feelings? ❑ YES ❑ NO
Have you ever taken a morning **Eye** opener? ❑ YES ❑ NO

STRESS RELATED

Have you been hospitalized in the last year?	YES	NO
Have you been hospitalized for more than 7 days in your lifetime?	YES	NO
How many hours do you work per week?	YES	NO
Are you satisfied with your work?	YES	NO
Do you feel under pressure at work?	YES	NO
Do you get along with your colleagues at work?	YES	NO
Do you get along with your spouse or partner?	YES	NO
Do you get along with other relatives?	YES	NO
Have any close relative been seriously ill in the past year?	YES	NO
Do you feel tension at home?	YES	NO
Do you feel lonely?	YES	NO
Do you have anyone whom you can trust and confide in?	YES	NO
Do you get along well with people?	YES	NO
Do you often feel overwhelmed by the demands of every day life?	YES	NO
Do you tend to be influenced by people with strong opinions?	YES	NO

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Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Patient Name: _____ Date of Birth: _____

STRESS RELATED (continued)

Do you tend to worry about what other people think of you?				YES	NO
Do you have difficulty breathing or feel you cannot get enough air?				YES	NO
Do you feel tired and lack energy?				YES	NO
Are you irritable?				YES	NO
Do you feel sad or depressed?				YES	NO
Do you feel tense or “wound up”?				YES	NO
Have you lost interest in most things?				YES	NO
Do you get “panic” attacks?				YES	NO
How would you rate your level of stress?	LOW	MEDIUM	HIGH	INTERMITTENT	HIGH
How do you rate the quality of your life?	EXCELLENT	GOOD	FAIR	POOR	AWFUL

Pregnancy/Infertility

Age of first menstrual period? _____ Date of last period: _____
Total # of pregnancies? _____ # of Live Births? _____ # of Miscarriages/abortions? _____

Did you have gestational diabetes?	YES	NO
Preeclampsia?	YES	NO
HELP Syndrome?	YES	NO
Hypertension during Pregnancy?	YES	NO
Did your doctor put you at bed rest during your pregnancy?	YES	NO
Did you have other obstetric complications?	YES	NO
What were the birth weights of your children? _____		
Do you consider yourself infertile?	YES	NO
Have you undergone any treatment for infertility?	YES	NO
Do you presently use Birth Control Pills?	YES	NO
Are you on hormonal replacement therapy?	YES	NO

Sleep History

Sleep plays a major role in overweight and obesity.
How much sleep do you get each night on average? ❑ 4-5 Hours ❑ 6-8 hours ❑ More than 8 hours

Do you have restless sleep?	YES	NO
Does it take a long time to fall asleep? How long on average? _____	YES	NO
Do you wake up early and have trouble falling back asleep?	YES	NO
Do you feel tired when you wake up in the morning?	YES	NO
What is your sleep environment like?	YES	NO
Dark Room:	YES	NO
Sleep with Dogs:	YES	NO
Do you have insomnia?	YES	NO
Do you take any sleep aid medications? If yes, what type? _____	YES	NO
Do you snore at night?	YES	NO
Has your sleep partner ever told you that you stop breathing while you are sleeping?	YES	NO

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NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Patient Name: _____ Date of Birth: _____

Please rate how likely you would be to actually *doze* off during each situation. Score your rating by circling a number from 0 to 3 points which best describes each situation and total your answers. Even if you have not done some of these things recently, try to recall how they would likely affect you.

0 points = Would never fall asleep
1 point = Slight chance of falling asleep
2 points = Moderate chance of falling asleep
3 points = High chance of falling asleep

	SITUATION				
A.	Sitting and reading	**0**	**1**	**2**	**3**
B.	Watching TV	**0**	**1**	**2**	**3**
C.	Sitting, inactive in a public place (e.g., theater or meeting)	**0**	**1**	**2**	**3**
D.	As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
E.	Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
F.	Sitting down and talking to someone	**0**	**1**	**2**	**3**
G.	Sitting quietly after a lunch	**0**	**1**	**2**	**3**
H.	In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**
	Totals				
			TOTAL		

Total up Score:
0-7 No abnormality; 8-9 Average Daytime Sleepiness; 10-15 Excessively sleepy and 16-24 Very Excessively sleepy.
The last two categories mean that further evaluation should be done.
(Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. 1991;14(6):540-5).

Psychosocial History

Screening Questions Psychosocial History –

Have you ever had:

Suicide attempt?	YES	NO
Family history of suicide?	YES	NO
History of Bipolar Disorder?	YES	NO
Obsessive Compulsive Disorder?	YES	NO
A phobia or avoidance of specific things or situations?	YES	NO
Post Traumatic Stress Disorder?	YES	NO

Over the last two weeks have you experienced any of the following:

Loss of interest in activities that you formerly enjoyed?	YES	NO
Guilt worthlessness/helplessness/hopelessness?	YES	NO
Reduced Energy?	YES	NO
Lack of concentration?	YES	NO
Appetite disturbance increased or decreased agitation?	YES	NO
Death of close family member or friend?	YES	NO

Abuse Assessment:

In the past year have you been hit, kicked, or physically hurt by another person?	YES	NO
Have you ever been in a relationship with someone who threatens or physically harms you?	YES	NO
Have you ever been forced to have sexual contact that you were not comfortable with?	YES	NO
Have you ever been abused? If yes, describe by whom, when and how: _____ _____	YES	NO

5100-0057
(01/2019)

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Patient Name: _____ Date of Birth: _____

Previous Bariatric Surgery

***Please complete this information if you have had a previous weight loss surgery procedure:**

Are you having problems with a previous procedure? ❑ YES ❑ NO
Are you interested in having a revision of a previous weight loss procedure? ❑ YES ❑ NO

Date of Procedure _____
Name of Surgeon who did the procedure? _____
How much did you weigh prior to the procedure? _____
What was your lowest weight after the procedure? How many months after the primary procedure was your lowest weight? _____
Did you have any readmissions to the hospital after surgery? ❑ YES ❑ NO
Why? _____
Did you have to go back to surgery for any reason after the original procedure? ❑ YES ❑ NO
Why? _____
What medical problems did you have prior to surgery? Please give a complete list _____
_____

Adjustable Gastric Band

What type of Band did you have placed? _____
Did you go for regular follow up and get fills? _____
How much fluid do you think is in your band? _____
Do you have a feeling of fullness? _____
Are you throwing up after meals? _____
When you get filled do you feel like you cannot eat? _____
When was your last fill? _____ How much fluid did they put in the band? _____
Have you had any complications of the band? Erosion? Slip or Prolapse? Problems with your Port? _____
_____
Do you want to have the band removed? _____
Do you want a secondary bariatric procedure? ❑ YES ❑ NO ❑ Sleeve Gastrectomy ❑ Gastric Bypass ❑ Duodenal Switch

Have you had a recent Upper Gastrointestinal Series? ❑ YES ❑ NO
Where did you have it done? _____
Have you had a scope (EGD) done to look at your surgery from the inside? ❑ YES ❑ NO
What physician did the EGD? _____
Do you have a copy of your operative report? ❑ YES ❑ NO _____

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(01/2019)

Banner Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

Organization Who Is Releasing Information	
Facility:	
Address:	
City, State	Zip Code
Fax:	Phone:

To Whom Information Will Be Provided	
Entity/Individual:	
Address:	
City, State	Zip Code
Fax:	Phone:

Patient Information:	Patient Name: _____ Date of Birth: _____ Address: _____ Phone Number: _____ _____
Dates Requested:	**FROM:** _____ **TO:** _____

***There May be a FEE Associated with your Request for Records**

Records Being Requested:

Health Center/Clinic Records
- ❑ Office Visit/Progress Note
- ❑ Immunization Record
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Laboratory Report
- ❑ Medication List
- ❑ EKG Report
- ❑ Imaging/X-ray Report
- ❑ Imaging/X-ray CD/Film _____
- ❑ Consultation
- ❑ Behavioral/Psychiatric Office visit
- ❑ Official Medical Record
- ❑ Other _____

Hospital Records (Only From Non-Banner Hospital)
- ❑ **All Pertinent Records** (includes those listed below)
  - ❑ Allergies
  - ❑ Consultation
  - ❑ Discharge Summary
  - ❑ ER Report
  - ❑ EKG Report
  - ❑ History & Physical
  - ❑ Laboratory
  - ❑ Medication List
  - ❑ Operative Report
  - ❑ Pathology Report
  - ❑ Problem List
  - ❑ X-Ray Report
- ❑ Other _____

Other Records:
❑ Billing Record ❑ Genetic Testing ❑ Photos
Further explanation of request: _____

Delivery of Records:

Paper Requests ❑ Mail ❑ Pick Up ❑ Courier ❑ Fax **Electronic Requests** ❑ E-mail ❑ CD
❑ I Do Not want my electronic record Encrypted ❑ I Do want my electronic record Encrypted
NOTE: There is some level of risk that a third party could access your Protected Health Information (PHI) without your consent when electronic media or email is unencrypted. We are not responsible for unauthorized access to unencrypted media or email or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address for record delivery

(Complete ONLY if requesting records via Email)
Unencrypted data sent by email can be intercepted by Unauthorized Parties

Purpose: ❑ Self ❑ Continuing Care ❑ Other (please specify): _____

Banner Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing: my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Banner will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Banner Health's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

I understand that I have a right to receive a copy of this authorization.

This Authorization pertains to the dates specified on this Authorization. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Banner Health, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

❑ Yes ❑ No DO THE REQUESTED RECORDS INCLUDE DRUG/ALCOHOL TREATMENT RECEIVED: If yes, I release my drug and alcohol information for the following purpose:

_____

The information to be released should include my entire record requested except for the following:

_____

Signature of Patient _____ Date _____

Signature of Legal Representative _____ Date _____

Relationship to Patient: _____

For Healthcare Use Only		
Employee printed name who completed/reviewed form with patient:		
Verbal Release or Viewed EMR (document information/person authorized):		
Date Received:	Date Completed:	Processing Initials:
POA Verified:	ID/License Verified:	
Comments for CROI:		

Records picked up by: _____ Date _____

1200-0004
(09/2017)