St. Mary's HOSPITAL
Advanced Wound Center

350 Boulevard Passaic, NJ 07055
973-365-4677

NEW PATIENT INFORMATION

PATIENT INFORMATION		
Patient #:		Preferred Language:
First Name: M.I.:		Address 1:
Last Name:		Address 2:
SSN:		City:
DOB:		State:
Gender: F M		Zip:
Ethnicity: □ African American □ Asian or Pacific Islander □ Caucasian □ Hispanic	□ Multi Racial □ Native American □ Other □ Unknown	Phone: Secondary Phone: Email Address:

ADMISSION INFORMATION		WOUND INFORMATION
Admission date to clinic:	How Heard: □ Physician □ Friend □ Relative □ Other patient □ Home Health □ Self Referral □ Other:	# of wounds:
Consult: □ Yes □ No		Location:
Palliative: □ Yes □ No		Etiology:
Medicare Admission: □ Yes □ No		Duration:
Non Wound Care Diagnosis: □ Yes □ No		Diagnostics:
New to Hospital: □ Yes □ No		Other:

CARE PROVIDERS AND INSTRUCTIONS	
Wound Care Physician:	Capable of Self Care: □ Yes □ No
Case Manager:	Caregiver: □ Yes □No , if yes are they doing W/C:
Referring Physician:	Caregiver First Name:
Primary Care Physician:	Caregiver Last Name:
Pharmacy Name:	Caregiver Phone:
Pharmacy Number:	**HOME HEALTH / LTC FACILITY INFO**
Advanced Directives: □ Yes □ No	Company Name:
Durable Power of Attorney/Healthcare: □ Yes □ No	Nurse:
Do Not Resuscitate: □ Yes □ No	Phone:
Living Will: □ Yes □ No	Fax:

INSURANCE INFORMATION	
Insurance Payer:	Name of Insured:
Classification: Primary / Secondary / Tertiary	Relationship of Insured:
Copay: $	***Policy Number:***
Is patient the Policy Holder: □Yes □ No	***Group Number:***
Insurance Payer:	Name of Insured:
Classification: Primary / Secondary / Tertiary	Relationship of Insured:
Copay: $	***Policy Number:***
Is patient the Policy Holder: □Yes □ No	***Group Number:***

Comments:

Appointment

Day: **Date:** **Time:**

Patient Label

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PATIENT NAME: _____

NEW PATIENT MEDICAL HISTORY

CHIEF COMPLAINT: (WHAT IS THE REASON FOR YOUR VISIT TODAY?)

_____

_____

HISTORY OF PRESENT ILLNESS:

LOCATION: (WHERE IS YOUR WOUND LOCATED?)

_____

DURATION: (HOW LONG HAVE YOU HAD THE WOUND?)

_____

CONTEXT: (HOW DID YOUR WOUND OCCUR OR DEVELOP?)

_____

ASSOCIATED SIGNS/SYMPTOMS: DESCRIBE ANY SIGNS OR SYMPTOMS OF YOUR WOUND (SUCH AS, DRAINAGE, ODOR, NUMBNESS, ETC.)

_____

_____

_____

_____

TIMING: (DO YOU HAVE PAIN IN OR AROUND THE WOUND?) ☐ No ☐ Yes

IF YES, IS THE PAIN ☐ CONSTANT *(HURTS ALL THE TIME)* OR ☐ INTERMITTENT *(COMES AND GOES)?*

QUALITY: (DESCRIBE YOUR PAIN BY CHECKING ALL THAT APPLY BELOW)

☐ ACHING ☐ BURNING ☐ THROBBING ☐ STABBING ☐ SHOOTING ☐ SHARP ☐ DULL ☐ HEAVY

☐ CRAMPING ☐ EXHAUSTING ☐ SPLITTING ☐ TENDER ☐ EASY TO PINPOINT ☐ DIFFICULT TO PINPOINT

MODIFYING FACTORS: (DESCRIBE OR LIST ANY CONDITIONS OR ACTIVITIES THAT IMPACT YOUR WOUND, SUCH AS PAIN WHEN WALKING OR RAISING YOUR LEG)

_____

_____

_____

** HAS YOUR WOUND EVER HEALED AND THEN RE-OPENED? ☐ No ☐ Yes

** HAVE YOU HAD ANY LAB WORK DONE IN THE PAST MONTH? ☐ No ☐ Yes; IF YES, WHERE:_____

** HAVE YOU HAD ANY TESTS FOR CIRCULATION IN YOUR LEGS? ☐ No ☐ Yes; IF YES, WHERE:_____

** WHO ORDERED ABOVE TESTS? LAB_____ CIRCULATION:_____

** HOW HAVE YOU BEEN TAKING CARE OF YOUR WOUND?

_____

_____

** *INFORMATION IS NOT COLLECTED IN THE CLINICAL DATABASE*

Advanced Wound Center

PATIENT NAME: _____

ALLERGIES: *(LIST ALL KNOWN ALLERGIES AND REACTIONS)*

☐ NO KNOWN ALLERGIES ☐ LATEX / RUBBER ☐ TAPE ☐ IODINE

☐ FOOD (LIST): _____

☐ MEDICATIONS (LIST): _____

☐ OTHER: (LIST):

ADVANCED DIRECTIVES & INSTRUCTIONS: *(CHECK ALL THAT APPLY)*

☐ I HAVE AN ADVANCE DIRECTIVE ☐ I HAVE A LIVING WILL

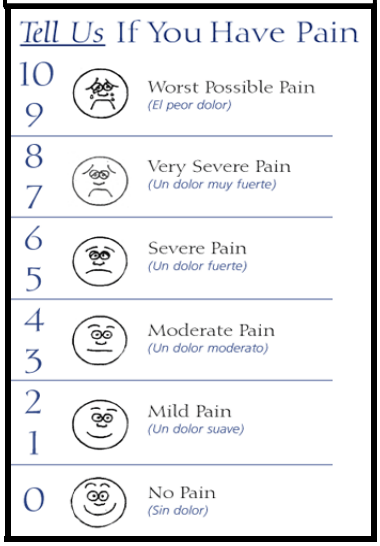
☐ ADVANCE DIRECTIVE MATERIALS WERE PROVIDED TO ME

☐ I HAVE A COPY OF MY LIVING WILL FOR THE HOSPITAL

☐ I HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE

☐ I DO NOT WANT TO BE RESUSCITATED

SEVERITY: CIRCLE THE NUMBERS THAT BEST DESCRIBE YOUR CURRENT LEVEL OF PAIN



REVIEW OF SYSTEMS / PAST MEDICAL & SURGICAL HISTORY

CONSTITUTIONAL (GENERAL HEALTH)

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Active			
Fatigue *(tired all of the time)*			
Fever			
Loss of Appetite			
Marked Weight Change			
Sedentary *(low activity level)*			
Night Sweats			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Influenza *(Flu)* Vaccine Current			
Pneumonia Vaccine Current			
Tetanus Vaccine Current			
Sleep Apnea			

ALLERGIC / IMMUNOLOGIC

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Rhinitis *(inflamed nasal passage)*			
Hay Fever			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
AIDS / HIV			
Lupus			
Pyoderma Gangrenosum			
Reynaud's Disease			
Rheumatoid Arthritis			

CARDIOVASCULAR (CENTRAL / PERIPHERAL)

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Dyspnea on exertion *(shortness of breath with activity)*			
Edema *(swelling)*			
Intermittent Claudication *(pain on exertion, i.e. walking to mailbox)*			

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PATIENT NAME: _____

Orthopnea *(shortness of breath when lying down)*			
Palpitations			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Congestive Heart Failure			
Coronary Artery Disease *(CAD)*			
Deep Vein Thrombosis *(clot in the vein)*			
Hyperlipidemia *(High cholesterol)*			
Hypertension *(High blood pressure)*			
Murmur			
Myocardial Infarction *(Heart attack)*			
Peripheral Vascular Disease			
Rheumatic Fever			
Vasculitis			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Coronary Artery Bypass Surgery			
Greenfield Filter			
Left Ventricular Assist Device			
Pacemaker/Defibrillator			
Peripheral Bypass surgery			
Stent Placement			
Subfascial endoscopic perforator surgery *(SEPS)*			
Valve Replacement			
Vein Stripping			
EAR / NOSE / MOUTH / THROAT			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Hearing Loss / Aid			
Otalgia *(ear ache)*			
Dental Problems			
Painful or Swollen Lymph Nodes			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Barotrauma *(damage to ear drum)*			
Sinusitis			
Tinnitus *(ringing in ears)*			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Myringotomy *(incision in eardrum)*			
Tube Placement *(in ear)*			
EYES			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Blurred Vision			
Dry Eyes			
Vision Changes			
Glasses / Contacts			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Cataracts			
Glaucoma			
Retinopathy *(damage to the retina)*			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Other			
ENDOCRINE			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Cold Intolerance			

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PATIENT NAME: _____

Heat Intolerance			
Polydypsia *(Excessive thirst)*			
Polyuria *(Excessive urination)*			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Gestational Diabetes *(with pregnancy)*			
Thyroid Disease			
Type 1 Diabetes *(juvenile onset)*			
Type 2 Diabetes *(adult onset)*			
GASTROINTESTINAL (GI)			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Bowel Incontinence			
Change in Bowel Habits			
Jaundice			
Nausea / Vomiting / Diarrhea			
Loss of Appetite			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Cirrhosis of the Liver			
Crohn's Disease			
Gastro Esophageal Reflux *(GERD)*			
Hepatitis *(liver infection)*			
Special Diet			
Ulcerative Colitis			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Colectomy *(remove part large colon)*			
Colostomy			
Ileostomy			
GENITOURINARY (GU)			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Frequency			
Urinary Incontinence			
Pregnant			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Benign Prostate Hyperplasia *(enlarged prostate)*			
Dialysis			
End Stage Renal Disease			
Kidney Disease			
Miscarriage			
Prostate Cancer			
Sexually Transmitted Disease			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Previous OB/GYN Surgery			
HEMATOLOGIC / LYMPHATIC			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Bruising			
Bleeding / Clotting Disorders			
Blood Transfusion			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Anemia *(low blood count)*			
Anticoagulant Therapy			
Lymphedema			
Sickle Cell Anemia			
INTEGUMENTARY (HAIR / SKIN / NAILS)			

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PATIENT NAME: _____

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Pruritis *(Itching)*			
Rash			
Skin Allergies			
Calluses/Corns			
Prone to Skin Tears			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Malignancy *(skin cancer)*			
Onchomycosis *(nail fungal infection)*			
Scleroderma			

MUSCULOSKELETAL

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Backache			
Contractures			
Deformities			
Muscle Pain			
Muscle Wasting			
Muscle Weakness			
Assistive Devices			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Arthritis			
Gout			
Hip Fracture			
Osteoarthritis			
Osteomyelitis *(bone infection)*			
Osteoporosis			
Other Fracture			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Achilles Tendon Lengthening			
Amputation			
Back Surgery			
Foot Surgery			
Implanted Surgical Hardware			
Joint Replacement			

NEUROLOGICAL

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Abnormal Gait			
Dizziness			
Loss of Protective Sensation			
Numbness			
Tingling			
Tremors			
Vertigo *(dizziness)*			
Weakness			
Headaches			
Paralysis			
Seizures			
Syncope *(brief fainting episode)*			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Amyotrophic Lateral Sclerosis *(ALS)*			
CNS Trauma Injury			
Epilepsy			
Head Injury / LOC			
Multiple Sclerosis			

Stroke			
Transient Ischemic Attack *(TIA / mini-stroke)*			

PSYCHIATRIC

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Anxiety			
Claustrophobia			
Insomnia			
Nervousness / Tension			
Memory Loss			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Alzheimer's			
Dementia *(loss of mental skills)*			
Depression			

RESPIRATORY

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cough			
Hemoptysis *(coughing blood)*			
Shortness of Breath			
Wheezing			
Oxygen in Use			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Abnormal Chest X-ray			
Asthma			
Chronic Obstructive Pulmonary Disease *(COPD)*			
Emphysema			
Pneumonia			
Pneumothorax *(collapsed lung)*			
Positive TB Test			
Pulmonary Embolus *(blood clot in lung)*			
Tuberculosis			
Upper Respiratory Infection *(URI)*			

ONCOLOGIC

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cancer			Type:
Receiving Chemotherapy			
Receiving Radiation			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Cancer			Type:
Received Chemotherapy			
Received Radiation			
Type of Cancer			

FAMILY & SOCIAL HISTORY

FAMILY HISTORY	YES	NO	COMMENTS
Cancer			
Diabetes			Type I: _____ Type II: ____ Date Onset: _____
Heart Disease			
Hypertension			
Kidney Disease			
Lung Disease			
Mental Illness			
Seizures			
Stroke			
Thyroid Problems			
Tuberculosis			

Advanced Wound Center

PATIENT NAME: _____

Social History	
Substance Abuse	☐ No ☐ Yes | Describe:
Alcohol Use:	☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Tobacco Use:	☐ Never ☐ Former ☐ Less than 1 Pack Per Day ☐ Greater than 1 Pack Per Day | Years:
Smokeless Tobacco Use:	☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Caffeine Use:	☐ Never ☐ Previously ☐ Currently | Type / Frequency:
Illicit Drug Use:	☐ Never ☐ Previously ☐ Currently | Type / Frequency:
Occupation:	
Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:
Children	☐ No ☐ Yes | If Yes, how many:
Cultural, Religious or Language Concerns:	
Support Systems Lacking:	
Transportation Concerns (able to drive, etc.)?:	
Able to Care for Self (dressing, bathing, etc.)? ☐ No ☐ Yes If "No", explain :	

MEDICATIONS - - Write on Back if more room needed

[Please list all medicines you are currently taking - - Include over the counter, herbal & vitamin supplements]

Medications	Amount / Dosage	How Often

NUTRITION ASSESSMENT / SCREEN

History	Yes	No	Action Plan
Difficulty Chewing or Swallowing **[1]**			
Do You Need Assistance with Eating **[1]**			
Have You Had a Weight Loss or Gain > 10 lbs in Past 6 Months **[2]**			
If Yes, _____ lbs in _____ months			Reason, if known:
Intentional Weight Loss from Program or Medications **[1]**			
Do You Follow a Special Diet **[1]**			
Do You Have Any Food Allergies **[1]**			
Do You Have a **Good** Appetite **[0]**			
Do You Have a **Fair** Appetite **[1]**			
Do You Have a **Poor** Appetite **[2]**			
Do You Take Nutritional Supplements **[0]**			
Do You Drink Several 8 oz Glasses of Water Each Day **[0]**			
RISK LEVEL: **Low** = less than or equal to 2 | **High** = greater than 3 (Staff Use Only)			**SCORE:**

General Notes

Patient Signature: _____ **Date:** _____ **Time:** _____
(Or Legal Guardian/POA)

I have reviewed the New Patient Medical History with the patient / caregiver as part of the Initial Nursing Assessment.

Nurse Signature: _____ **Date:** _____ **Time:** _____

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ADVANCED WOUND CENTER PATIENT BILLING INFORMATION

The Advanced Wound Center (AWC) at St. Mary's Hospital serves as a hospital outpatient department where doctors and nurses treat people with wounds that may have been present for a long time. Many times these visits will only result in a charge for a procedure such as a wound debridement, but sometimes they may also include a clinic visit. Sometimes, there may be charges for hyperbaric oxygen therapy, laboratory tests, x-rays, and other services that may be performed either in the Center or in the hospital.

Visits to the Wound Center will result in charges from <u>both</u> the *Hospital* and *Doctor*:

We understand this can be a confusing time and this document outlines the various ways payment of the services provided to you can be handled. If you have questions about the process, please feel comfortable discussing this with one of the Center staff members.

THE HOSPITAL:
When the *hospital* bills your insurance company for the services you received at the Wound Center, the bill contains charges for the **<u>technical component</u>** of those services. This fee includes the use of the Center's personnel, room, equipment, as well as any supplies that were used. You may also see laboratory charges, radiology (x-ray) charges, and other additional services if they were provided during that billing period. Some hospitals may bill for these additional services on a separate bill.

THE DOCTOR:
Each *doctor* that sees and treats you in the Wound Center will bill for their services separately. Most of the time, this bill will come from his or her office, but sometimes a billing company may send you a bill for the doctor's charges. These charges will be for the **<u>professional component</u>** of the services and includes only the services that the doctor provided.

The Wound Center doctors are specially trained in providing wound care and the insurance company(s) will know to pay for only one set of services by the codes used on the bill sent to them. They will pay a portion of the service to the hospital and a portion to the doctor. **You will not be billed twice for the same service** even though the <u>description</u> of the services may be the same.

OTHER DOCTORS:
There are different specialists that may be called in on your case, depending on the difficulty of your wounds, and they may submit a bill as well. These may be from the Pathologist for the professional component of the laboratory tests performed, or the Radiologist for the services rendered when x-rays were performed, etc.

These billing practices are consistent within all departments of the hospital as well as within the hospital industry. In addition, these billing procedures are frequently audited by Medicare / Medicaid and accepted as standard practice.

IF YOUR PRIMARY INSURANCE IS MEDICARE OR MEDICAID:
The hospital will bill Medicare / Medicaid and may send you a courtesy copy of your itemized bill upon request. Medicare / Medicaid will notify you when they have paid their portion of your hospital bill. If you have a secondary insurance, the hospital will also send them a bill for their portion and that company will contact you to let you know when and what they paid to the hospital. After payments are received by either your primary and/or secondary insurance, **any outstanding balances will be your responsibility**.

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IF YOUR PRIMARY INSURANCE IS AN INDIVIDUAL / GROUP PPO OR HMO:
The hospital will bill your insurance company. **You will be responsible for any deductible and/or co-payment amounts**. Payment for these items may be expected at the time of service. Insurance verification will help us to identify your appropriate deductible and co-payment amounts.

IF YOU DO NOT HAVE INSURANCE COVERAGE:
Many hospitals require a payment (either in full or partial) at the time of the visit. If you are unable to pay, many hospitals will work with you to determine if you qualify for some type of assistance or will allow you to set up a payment plan. The Center can refer you to the Business Office as needed. You cannot be seen in the Wound Center until these arrangements are completed.

IF YOU DO NOT PAY YOUR BILLS:
As indicated before, you have a responsibility to pay for certain portions of your care and the hospital is willing to make payment options available. However, if you do not make any attempts to make payments to the hospital or doctor, the Center may find it necessary to discharge you back to your primary care physician due to non-payment. **It is very important that you make payment arrangements for your care at the Center.**

IF YOU HAVE QUESTIONS REGARDING YOUR BILLS / STATEMENTS:
Please call the hospital Patient Accounts department between 9:00 am and 4:30 pm (Monday thru Friday) at 973-470-3013. If your question is regarding the physician's services, you will need to contact that physician's office directly.

Patient: _____ Date / Time: _____
Signature

Witness: _____ Date / Time: _____
Signature

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PATIENT CARE CONTRACT

Patient Responsibilities To Ensure Wound Healing:

[Patient to initial each line signifying agreement]

_____ **LOCAL WOUND CARE** - I agree to cleanse my wound and apply my dressing as directed by my Advanced Wound Center physician. I realize I am also responsible for notifying the Advanced Wound Center staff immediately if I am having problems or questions concerning my wound and how I should be caring for it.

_____ **OFFLOADING** - I agree to relieve pressure from my wound as prescribed by my Advanced Wound Center physician. This may include, but is not limited to the following: wearing of special shoes or braces, utilizing crutches or a wheelchair, and/or limiting my walking, weight bearing, or sitting.

_____ **CONTROL SWELLING** - I agree to use swelling control methods as prescribed by my Advanced Wound Center physician which may include any or a combination of the following: using a compression pump, elevating my legs often throughout the day, and wearing compression wraps, or compression stockings. I will avoid standing or sitting with my legs dependent (hanging down) to help reduce/prevent the swelling.

_____ **APPOINTMENTS** - I agree to keep all scheduled Advanced Wound Center appointments. I also agree to attend all HBO treatments, if initiated.

_____ **GOOD HEALTH PRACTICES** - I agree to follow any diet, exercise or exercise restrictions that are advised by my Advanced Wound Center physician. I agree to follow any treatment plan advised by my primary physician to help control my diabetes or any other medical conditions which may slow my wound healing.

_____ **SMOKING** - I agree to participate in a program to help me stop smoking because I realize that this habit will prevent or slow down my wound healing.

_____ **NON-COMPLIANCE** - I understand that if I do not follow the treatment plan developed / prescribed for me by my Advanced Wound Center physician, I might be discharged from the program.

_____ _____
Patient / Other Legally Responsible Party (Relationship to patient) Date / Time

_____ _____
Witness (Sign and print name) Date / Time

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CONSENT FOR PHOTOGRAPHY

I hereby authorize and consent that photographs and/or video of me and/or my wound may be taken while I am a patient at the St. Mary's Hospital Advanced Wound Center (AWC). I understand that the photographs and/or video may be taken by my attending physician or any agent or employee of the AWC. I further understand that such photographs may be used for the assessment and evaluation of my wound as well as educational purposes and may be published, shown, exhibited or otherwise used by the AWC and its authorized affiliate, as they deem proper. I hereby consent to such use of photographs and video, and release the Advanced Wound Center, my physician, and agents and employees of this Center from all liability related to the taking and use of such photographs and/or video.

Patient's Signature: _____ Date / Time:_____

Witness Signature: _____ Date / Time:_____

NOTE: When the patient is a minor or otherwise legally incompetent, the legal guardian has the authority to authorize medical services. However, any minor patient who can understand this form should be given the opportunity to sign it in addition to the legal representative.

Signature of Patient's Legal Representative:

_____ Date / Time: _____

Relationship: _____

Witness Signature: _____ Date / Time: _____