



VALLEY WOUND CARE SPECIALISTS

Demographics:

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

Home address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Home/ Cellular/ Work Email: _____

Emergency Contact Name and Phone Number: _____

Pharmacy Name/ Phone number: _____ Cross Streets: _____

Primary Care Provider: _____ Referring physician: _____

Today's Visit:

Reason for today's visit: _____ When did symptoms start: _____

Is it work related? No Yes Workman's Comp Involved? No Yes

Is this related to an accident? No Yes → Auto Other _____

Is there legal action pending regarding this? No Yes → Attorney Name & Number _____

Physicians involved in your care: Please list all of your current doctors and specialists.

<u>Physician Name</u>	<u>Specialty</u>	<u>Phone Number</u>

Allergies: Are you allergic to anything? No Yes → list all drug/environmental allergies including adverse reaction:

<u>Allergic to:</u>	<u>Reaction</u>

Medications: Please list all medications including prescription, over the counter, herbs and supplements:

Medication Name	Dose and Frequency	Prescribing Physician

Past Medical History: Have you had/experienced any of the following?

- | | | | |
|--|---------------------------------|--|-----------------------------------|
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Amputation | <input type="checkbox"/> No <input type="checkbox"/> Yes | Insulin Pump |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | Joint Pain |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Anxiety | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Infections |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Atrial Fibrillation | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Stones |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Blood Transfusions | <input type="checkbox"/> No <input type="checkbox"/> Yes | Leg Wounds |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | CAD | <input type="checkbox"/> No <input type="checkbox"/> Yes | Multiple Sclerosis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | Myocardial Infarction |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cardiac Pacer | <input type="checkbox"/> No <input type="checkbox"/> Yes | Neurogenic Bladder |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cardiovascular Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Neurogenic Bowl |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | CHF | <input type="checkbox"/> No <input type="checkbox"/> Yes | Neuropathy |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Chicken Pox | <input type="checkbox"/> No <input type="checkbox"/> Yes | Obesity |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Chronic Foley Catheter | <input type="checkbox"/> No <input type="checkbox"/> Yes | Obstructive Sleep Apnea |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cirrhosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteoarthritis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Colitis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteoporosis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | COPD | <input type="checkbox"/> No <input type="checkbox"/> Yes | PAD |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Chron's Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Paraplegia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | CVA | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pneumonia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Depression | <input type="checkbox"/> No <input type="checkbox"/> Yes | Prior Flap Reconstruction |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | DVT | <input type="checkbox"/> No <input type="checkbox"/> Yes | Progressive Neurological Disorder |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | DM type 1 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pulmonary Disease |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | DM type 2 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Quadriplegia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Seizures | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Fecal Incontinence | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatoid Arthritis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Foot Wound | <input type="checkbox"/> No <input type="checkbox"/> Yes | Shingles |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Fracture | <input type="checkbox"/> No <input type="checkbox"/> Yes | STD |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Gastric Ulcer | <input type="checkbox"/> No <input type="checkbox"/> Yes | TIA |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Gastrointestinal Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tuberculosis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Gastroesophageal Reflux Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Urinary Incontinence |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Glaucoma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Valvular Problems |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Gout | <input type="checkbox"/> No <input type="checkbox"/> Yes | Venous Insufficiency |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Murmur | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis | Other: _____ | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | High Cholesterol | Other: _____ | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hypertension | Other: _____ | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hyperthyroidism | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Hypothyroidism | | |

Hospitalizations:

Date:

Reason:

Surgical History:

Date:

Procedure:

Social History:

Occupation: _____

Highest level of education: _____

Marital Status: (circle one) Single / Married / Divorced / Widow / Separated

Race: _____

Alcohol Use: Never / Beer drinker / Wine drinker / Recovering alcoholic / Social Use / Occasional / Moderate

Caffeine Use: How many servings per day? Occasional / 1 / 2 / 3 / 4+

Current Tobacco Use: Yes / No If yes: How many years have you smoked? _____ How many packs per day? _____

Past Tobacco User: Yes/No When did you quit? _____

Drug Use: Yes / No

Body Piercings: Yes / No

Tattoos: Yes / No

Do you use Sun Protection? Yes / No

Exercise Habits: Sedentary / Moderate / Strenuous

Do you wear seatbelts? Yes / No

Are you sexually active? Yes / No Birth Control method: _____

Preventative Care: (please enter DATES to all that apply) When was your last:

A1c %: _____

ABI/TBI: _____

Blood glucose: _____

Bone Density: _____

Chest X-ray: _____

Colonoscopy: _____

Dental Exam: _____

Dilated eye exam: _____

DTaP Vaccine: _____

Echocardiogram: _____

Flu Vaccine: _____

Foot exam: _____

Hep A Vaccine: _____

Hep B Vaccine: _____

HIV test date: _____

INR: _____

Last Physical exam: _____

Lipids: _____

Mammography: _____

MMR Vaccine: _____

Meningococcal vaccine: _____

Pap smear: _____

Pneumococcal vaccine: _____

PSA: _____

Pulmonary Function Test: _____

Routine eye exam: _____

Stool Occult Blood: _____

Stress Test: _____

Td Vaccine: _____

Tuberculin PPD: _____

Varicella: _____

Zoster Vaccine: _____

Family History: Check appropriate response:

Mother: Alive/ Deceased

Father: Alive/ Deceased

Does anyone in your family have history of:

Alcoholism: Mother Father Siblings Child

Anemia: Mother Father Siblings Child

Anxiety: Mother Father Siblings Child

Asthma: Mother Father Siblings Child

Birth Defects: Mother Father Siblings Child

CAD: Mother Father Siblings Child

Cancer: Mother Father Siblings Child Type: _____

Cardiovascular Disease: Mother Father Siblings Child

CHF: Mother Father Siblings Child

Congenital Anomaly: Mother Father Siblings Child

COPD: Mother Father Siblings Child

Chron's Disease: Mother Father Siblings Child

Depression: Mother Father Siblings Child

Epilepsy: Mother Father Siblings Child

GERD: Mother Father Siblings Child

Hypocholesteremia: Mother Father Siblings Child

Hyperlipidemia: Mother Father Siblings Child

Hypertension: Mother Father Siblings Child

Hyperthyroidism: Mother Father Siblings Child

Kidney Disease: Mother Father Siblings Child

Liver Disease: Mother Father Siblings Child

Osteoarthritis: Mother Father Siblings Child

Osteoporosis: Mother Father Siblings Child

Pulmonary Disease: Mother Father Siblings Child

Stroke: Mother Father Siblings Child

Substance Abuse: Mother Father Siblings Child

Review of Systems: Please check all that apply:

GENERAL <input type="checkbox"/> Unexpected Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	HEART <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmurs <input type="checkbox"/> Fainting <input type="checkbox"/> Palpitations <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	URINARY <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Bleeding <input type="checkbox"/> Difficult/Painful Urination <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	MUSCLE/JOINTS <input type="checkbox"/> Joint Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Instability <input type="checkbox"/> Redness <input type="checkbox"/> Heat <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all
EYES <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Corrective Lens <input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye Redness <input type="checkbox"/> Watering <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	LUNGS <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Snoring <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	ENDOCRINE <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> Excessive Urination <input type="checkbox"/> High Blood Sugar <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	NEUROLOGIC <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremors <input type="checkbox"/> Unsteady Gait <input type="checkbox"/> Seizure <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all
EAR/NOSE/THROAT <input type="checkbox"/> Headache <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Earache <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	STOMACH/COLON <input type="checkbox"/> Heart Burn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody/Tarry Stools <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	BLOOD <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> Blood Clots <input type="checkbox"/> Anemia/Low Blood Counts <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	SKIN <input type="checkbox"/> Redness <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Poor Healing <input type="checkbox"/> Skin Changes <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all
MENTAL HEALTH <input type="checkbox"/> Anxiety <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all	ALLERGIC <input type="checkbox"/> Foods <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Hay Fever <input type="checkbox"/> Other <input type="checkbox"/> Check box if NO to all		

Screening:

Have you had any recent falls? Yes / No If yes- when? _____

Have you recently been feeling depressed with little interest in doing things, feeling down or hopeless? Yes / No

Are you currently under the care of a counselor, psychiatrist, or social worker? Yes / No If Yes, Name: _____

Have you in the past or currently been the victim of physical or sexual abuse? Yes / No

Advanced Care Planning:

Do you have:

Living Will: No Yes

DNRO: No Yes

Guardian: No Yes

Healthcare POA: No Yes

Surrogate Decision Maker: No Yes

Anything else you would like your provider to know or be aware about?

I attest that the information provided is accurate and described to the best of my ability.

Signature

Date

Printed Name



VALLEY WOUND CARE SPECIALISTS

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. The Notice contains your Patient Rights that describes your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

(Patient Signature)

(Date)

(Printed Name)

Witness: _____

(Practice Representative)

(Date)



VALLEY WOUND CARE SPECIALISTS

Conditions of Treatment

Consent to Medical, Wound and Related Healthcare: I agree to the treatment for medical care and the treatment and/or procedures that my doctor thinks are needed. I understand that my doctor will decide on the care I receive at Valley Wound Care Specialists.

Medical and Allied Health Care Providers: I understand that my care will be provided by Physicians and/or Allied Health Providers (Nurse Practitioners and Physician Assistants). Everyone will work under a supervising physician and work together and aim for positive patient outcomes.

Teaching Programs: Valley Wound Care Specialists has agreements with medical schools that teach medicine to future doctors, nurses and other health professionals. I understand that medical students, nursing students and/or other health profession students may assist with my care.

Consent for Photography: I consent to having my photograph taken for identification purposes. I consent to photographs taken during my medical and surgical procedures and the use to track my wound healing progress. The term "photograph" includes both video and still photography in a digital format. I understand that Valley Wound Care Specialists owns all rights to these photos. I release my right to them.

Release of Information: I understand that Valley Wound Care Specialists will treat my medical information as confidential; however, I understand that information will be shared with other providers directly involved in my care or involved in the payment for my care. I agree to the release of information in my medical record as needed.

Assignment of Benefits: I authorize payment to Valley Wound Care Specialists for any types of payment due from Medicare, Medicaid, Commercial insurance or any other third party payer.

Payment: I agree to pay copayments, co-insurances and/or deductibles at the time services are rendered. I understand that this payment may be in the form of cash, check with identification, and major credit cards (Visa, MasterCard, Discover, or American Express.)

Advanced Directives: I understand that if I have any advanced directives, Living Will or healthcare Power of Attorney, I will provide a copy to Valley Wound Care Specialists to be kept on file should it need to be referenced.

(Patient Signature)

(Date)

(Printed Name)



VALLEY WOUND CARE SPECIALISTS

Care Agreement

Agreement to receive wound care between: VALLEY WOUND CARE SPECIALISTS and:

(Patient Name)

I understand that in order for my wound healing treatment to prove effective, I must comply and adhere to the treatment outlined by my provider. Treatment is most effective on a regular reoccurring basis and I understand that missed or sporadically attended appointments are not best for my healing.

The recommended treatment program by Valley Wound Care Specialists is to be seen _____.
(Frequency)

I understand that in order for me to receive wound care treatment from Valley Wound Care Specialist, I agree to the following conditions:

1. I will appear for treatment appointments as scheduled.
2. I will follow my treatment regimen as prescribed for me to the best of my ability.
3. I will inform Valley Wound Care Specialists if I find myself unable to comply.
4. If I am unable to make a scheduled appointment, I will notify Valley Wound Care Specialists as soon as possible and I will also try to reschedule per my treatment plan.
5. I will not miss more than 2 days of treatment during my treatment plan.
6. I understand that a violation of these conditions may result in my discharge from Valley Wound Care Specialists.
7. I understand that there may be fees associated with my care:
\$35.00- NSF/ Returned Check
\$35.00- No Show Appointment Fee- When you are not present for your scheduled appointment.
\$25.00- Same Day cancellation. We do require that you provide 24 hours notice when rescheduling.
\$35.00- Paperwork completion: Disability forms/ FMLA/ HR/ Other forms

I accept the above terms as a condition of my receiving treatment at Valley Wound Care Specialists.

(Patient Signature)

(Date)

(Printed name)

(Phone number)



WOUND DEBRIDEMENT CONSENT

This consent form provides a written communication of the recommended surgical procedure(s) to be performed. It will allow you to give or withhold your consent to the proposed procedure(s).

Patient Name _____

1. Procedure(s) proposed:

Conservative Sharp Debridement/Non-Excisional Debridement: which is removing necrotic or dead tissue from the existing wound to promote granulation to facilitate wound healing. During the debridement process, further exploration of the wound site may require the more invasive Excisional Wound Debridement as described below.

Excisional Wound Debridement: which is removing necrotic or dead tissue along with viable tissue surrounding the existing wound to promote granulation to facilitate wound healing.

Procedure site(s): _____

Performed by: _____

Type of anesthesia: None Local Other _____

2. Risks/Benefits:

All surgical procedures involve risks and benefits and no guarantee is made as to result or cure. You have the right to be informed of the proposed procedure(s): benefits, side effects of the proposed procedure(s), the likelihood of achieving treatment goals, reasonable alternatives, side effects of the alternatives, and possible results of not receiving care or treatment. The following additional risks and potential complications may occur in connection with this particular procedure: Blood loss requiring blood transfusion, nerve damage, and damage to healthy tissue. If your provider determines that there is a reasonable possibility that you may need a blood transfusion as a result of the procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the options for blood transfusion.

3. Authorization and Consent: Your signature on this form indicates that:

- You have read and understand the information provided in this form.
- Your provider has adequately explained to you the proposed procedure(s) and the anesthesia set forth above. The discussion included the risks, benefits, consequences, alternatives and other pertinent information and you do not need further explanation.
- You have had a chance to ask your provider(s) questions and obtain answers to your satisfaction.
- You authorize and consent to the performance of the proposed procedure(s) and anesthesia.
- You impose no specific limitations regarding the use or disposal of any tissue removed during the procedure.

Patient Signature: _____ Date: _____

Printed Name: _____

PROVIDER CERTIFICATION: I hereby certify that I have discussed the procedure(s) described above with the patient (or patient's legal representative). The discussion was held prior to procedure and included the risks/benefits, consequences/alternatives and other pertinent information about the proposed procedure(s).

Signed: _____ Date: _____