Welcome to Valley Wound Care Specialists. Please fill out this packet to the best of your ability.

Demographics:

Patient Name: ____ Date of Birth: ___________ Age: ______

Home address: ____City: _______________ State: ____ Zip: _________

Phone number: _______________________ Home/ Cellular/ Work Email: ___________________________________

Emergency Contact Name & Phone Number: ____

Pharmacy Name/Phone number: ____ Cross Streets: ____________________

Primary Care Provider: ______________________________ Referring physician: _________________________________

Insurance Plan/Carrier: ___________________________________ Insurance Ph number: ___________________________

Insurance ID Number: __________________________________ Insurance Group number: _________________________

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.

Physician Name	**Specialty**	**Phone Number**

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

Allergic to:	**Reaction**

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

Name	**Dose**	**Frequency**

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

□ No □ Yes Amputation Type:____________
□ No □ Yes Anemia
□ No □ Yes Anxiety
□ No □ Yes Asthma
□ No □ Yes Atrial Fibrillation
□ No □ Yes Bowel Incontinence
□ No □ Yes Coronary Artery Disease
□ No □ Yes Cancer Type:_____________
□ No □ Yes Cardiac Pacer/Defibrillator
□ No □ Yes Congestive Heart Failure
□ No □ Yes Chronic Foley Catheter
□ No □ Yes Cirrhosis
□ No □ Yes Colitis
□ No □ Yes COPD
□ No □ Yes Crohn's Disease
□ No □ Yes Cerebral Vascular Accident (Stroke)
□ No □ Yes Depression
□ No □ Yes Diabetes Mellitus Type 1
□ No □ Yes Diabetes Mellitus Type 2
□ No □ Yes DVT/Blood Clot
□ No □ Yes Fecal Incontinence
□ No □ Yes Foot Wound
□ No □ Yes Gastric/Duodenal Ulcer
□ No □ Yes Gastrointestinal Disease
□ No □ Yes Gastroesophageal Reflux Disease
□ No □ Yes Gout
□ No □ Yes Heart Murmur
□ No □ Yes Hepatitis
□ No □ Yes High Cholesterol
□ No □ Yes Hypertension
□ No □ Yes Hyperthyroidism
□ No □ Yes Hypothyroidism
□ No □ Yes Insulin Pump
□ No □ Yes Kidney Disease
□ No □ Yes Dialysis M T W Th F S

□ No □ Yes Kidney Stones
□ No □ Yes Leg Wounds
□ No □ Yes Multiple Sclerosis
□ No □ Yes Myocardial Infarction
□ No □ Yes Neurogenic Bladder
□ No □ Yes Neurogenic Bowel
□ No □ Yes Neuropathy Location: ____________
□ No □ Yes Obesity
□ No □ Yes Obstructive Sleep Apnea
□ No □ Yes Osteoarthritis
□ No □ Yes Osteoporosis
□ No □ Yes Paraplegia
□ No □ Yes Pain Pump
□ No □ Yes Peripheral Arterial Disease
□ No □ Yes Prior Flap Reconstruction
□ No □ Yes Progressive Neurological Disorder
□ No □ Yes Pulmonary Disease
□ No □ Yes Quadriplegia
□ No □ Yes Rheumatic Fever
□ No □ Yes Rheumatoid Arthritis
□ No □ Yes Seizures
□ No □ Yes TIA
□ No □ Yes Tuberculosis
□ No □ Yes Urinary Incontinence
□ No □ Yes Valvular Heart Disease
□ No □ Yes Venous Insufficiency

Other: ____________________________________

Other: ____________________________________

Other: ____________________________________

Other: ____________________________________

Hospitalizations:

Date	**Reason**

Surgical History:

Date	Procedure

Social History:

Smoking Status: □ Never Smoked □ Current Smoker How long have you smoked?__________ Amount per day:___________ □ Quit Date:___________ Past amount per day:___________

□ Other Tobacco Use Type:______________

□ Independent
□ Marital Status: _______________________
□ Occupation: _________________________
□ Religion: ____________________________
□ Caffeine Use Amount:_________________
□ Alcohol Use Amount:_________________
□ Illicit Drug Use _______________________
□ Hx Substance Abuse
□ Hospice Care- Name: __________________
□ Mental health concerns
□ In counselling
□ Hx of Self-Harm
□ Thoughts of Self-Harm
□ Needs assistance with repositioning

□ Live Alone
□ Lives with: ____
□ Retired
□ Requires Some Assistance with Care
□ Unable to care for self
□ Assisted Living/Group Home Name: ___________________________
□ Long Term Care Facility Name: ___________________________
□ SNF Name: ___________________________
□ Transportation concerns
□ Self Care and Mobility
□ Needs assistance with dressing
□ Needs assistance with toileting
□ Needs assistance with transfers

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

ABI/TBI: ____________________________
Blood glucose: ________________________
Echocardiogram: ______________________
Foot exam: ___________________________
Pneumococcal vaccine: ________________

Arterial/Venous Ultrasound: ___________________
Chest X-ray: ________________________________
Flu Vaccine: ________________________________
HgBA1c %: _________________________________
Routine eye exam: ___________________________

Family History:

Check appropriate response. Does anyone in your family have history of:

Unknown History: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling
Bleeding Disorders: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling
Autoimmune Disease: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling
Cancer: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling

Diabetes:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Heart Disease:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Hereditary Spherocytosis:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Hypertension:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Kidney Disease:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Lung Disease:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Skin Cancer:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Mental illness:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Myocardial Infarction:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Seizures:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Sickle Cell Anemia:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Stroke:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Tuberculosis:	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling
Other: ______________	□Mother	□Maternal Grandparent	□Father	□Paternal Grandparents	□Sibling

Review of Systems:

Please check all that apply:

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

Screening:

Fall History

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

Depression

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: ___________________

Abuse

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

VWCS Notes:

____
____
____
____
____
____
____

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 care for the use of tracking my wound healing progress. The term "photograph" includes both video and still photography in a digital format. I hereby grant permission to Valley Wound Care Specialists to use photographs, digital images, and/or digital files of me and/or my wound(s) for use anonymously in but not limited to: marketing materials, wound healing progress, and/or educational materials. These materials might include printed or electronic publications, web sites or other electronic communications. I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and files shall be the property of Valley Wound Care Specialists.

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)

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)

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)

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: _____________________