UPMC LIFE CHANGING MEDICINE

WELCOME TO THE UPMC LIVER CANCER CENTER

PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

You are scheduled to have an appointment at the UPMC Liver Cancer Center which is located in the UPMC Montefiore Hospital, 7th floor (which is the main floor), Frank Sarris Outpatient Clinic area. If parking in any UPMC garage, please remember to bring your parking ticket for validation to receive a discounted parking rate. As we are committed to your health and value your time, we ask that you do not report to our clinic any earlier than **15 minutes prior to your actual appointment time**. We must adhere to our set schedule to give every patient our full and undivided attention.

We will need the following items to prepare for your appointment:

- **Patient Assessment Form**: Please fill out and bring to your appointment the four page form that is enclosed in this packet. Please list ALL medication names, dosage, and how many times a day you take the medication; also include any over the counter and herbal medications you may take. Please list ALL physicians that take part in your care including address, phone number and fax number if available.

- **Release of Information Form**: Please fill out and bring this form with you to your appointment. The **only area** you need to fill in is your name, date of birth, social security number, and a signature.

- **Insurance Card(s)**: If your insurance requires you to have a referral, please obtain this prior to your appointment and have the doctor's office fax it to us at 412-692-2002.

- **CT scans/MRI/Ultrasounds (ONLY IF NECESSARY)**: Please obtain a copy of all scans and testing that you have had done from another hospital other than UPMC. You may carry these with you to your appointment.

- **Liver biopsy and pathology slides (ONLY IF NECESSARY)**: Please obtain a copy of your liver biopsy slides from any hospital other than UPMC. You may hand carry these slides with you to your appointment.

If you have any questions pertaining to your appointment or any of the information contained within, please call the Liver Cancer Center and your nurse coordinator or office staff will help in any way, 412-692-2001. Please remember that if your name, address, phone number, or insurance information changes during your course of treatment at the Liver Cancer Center, please notify our office.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____to release information from the record of:

(Name of Facility/Person)

_____ _____ _____ as described below to:

Patient Name **Birth Date** **Last 4 digits SSN/MRN**

_____ _____ _____

Facility/Person to Receive Records **Phone** **FAX**

Mailing address of facility or person to whom records are to be released:

_____ _____ _____ _____

Street **City** **State** **Zip Code**

A. Records are requested for the purpose of: ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance
(*Please check one):* ☐ Other: _____ ***Note: Purpose is not required for patient access.***

B. Disclosure Format ☐Paper ☐ CD ☐ FAX (Providers Only) _____ _____ ☐ Other:_____
Method Received ☐ US Mail ☐ In-Person Pickup ☐ FAX (Providers Only) *(fax number):* _____
☐ Email: _____ ☐ Direct Address:_____

C. Parts 1 and 2 below must be completed to properly identify the records to be released.

1. Type of records to be released and date(s) of service (check all that apply):

☐ Inpatient – Dates: _____ ☐ Emergency Dept- Dates: _____ ☐ Physician Office/Clinic – Dates: _____
☐ Same Day Surgery – Dates: _____ ☐ Outpatient – Dates: _____ ☐ Other – Dates: _____

2. Specific information to be released (check all that apply): **** For Radiology Images, please contact location where test was performed***

☐ Abstract (H&P, Consult, Test Results, Discharge Summary)

☐ Allergies	☐ Emergency Department Report	☐ Operative Report	☐ Problem List
☐ Consultation Report	☐ History & Physical Exam	☐ Pathology Report	☐ Procedure List
☐ Diagnostic Tests (cardiology studies, ECHO, EEG, EMG, pulmonary function, audiology)		☐ Physician Office/Clinic	☐ Psych Evaluation
☐ Discharge Instructions	☐ Laboratory Report/Test	☐ Physician Orders	☐ Radiology Report*
☐ Discharge Summary	☐ Medication Administration Records	☐ Physician Progress Notes	☐ Rehabilitation Records
☐ EKG Report	☐ Nurses Notes		

☐ Other, specify: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ Do not release

A CHECK MARK IS REQUIRED to release information from a licensed mental health facility, licensed drug and alcohol facility.

☐ Drug/Alcohol ☐ Mental Health (Psychiatric)

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.**
If applicable, specify other expiration date/event here: _____

_____ _____ _____ _____

Date of Signature **Signature of Patient** (14 years of age or older) may authorize release of inpatient & outpatient mental health information from a licensed facility. A minor can authorize release of Drug & Alcohol treatment information from a licensed facility.

Date of Signature **Signature of Authorized Representative**
Appropriate paperwork required.

☐ Parent or Legal Guardian (copy of guardianship order attached)
☐ Power of Attorney (copy attached)
☐ Next of Kin of Deceased (copy of death certificate attached)
☐ Executor of Estate (letter of administration or testamentary attached)

_____ _____

Date of Signature **Signature of** Staff Member obtaining consent during hospitalization (Required for release of Behavioral Health Records)

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

_____ _____ _____ _____

Date **Witness #1** **Date** **Witness #2**

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Authorization for Release of Protected Health Information

Additional Patient Rights and Responsibilities

Please be aware that health care facilities are authorized by Pennsylvania State law to charge for reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of a redisclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim. To revoke your Authorization, please send your request in writing to the facility listed on the front of this form.
- UPMC will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.
- By signing this authorization, the patient/requestor acknowledges and understands the risk associated with the communication of emails between UPMC and the recipient and consent as outlined herein, as well as other instructions that UPMC may impose to communicate via email.
- I am entitled to a copy of this completed Authorization form.

PATIENT ASSESSMENT FORM FOR NEW PATIENTS

Patient's Name:_____ Date:_____
Social Security Number:_____ Email Address:_____

Occupation:_____Date of Birth:_____Male ☐ Female ☐

Is today's visit for a second opinion? Yes ☐ No ☐
Reason for today's visit:_____

Self-Referral ☐ PCP ☐ Oncologist ☐ Friend ☐ Web Site ☐

Internet ☐ Other:_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING CONDITIONS?

Condition	Yes	NO	Condition	Yes	No
Mitral Valve Prolapse			Shortness of Breath		
Heart Disease			Cough		
High Blood Pressure			Asthma		
Chest Pain			Bronchitis		
Rheumatic Fever			Thyroid Disease		
An Abnormal Cardiogram			Diabetes		
Heart Attack			Low Blood Sugar		
Anemia			Recent Weight Gain/Loss		
Headaches			Loss of Urine		
Seizures/Convulsions			Bladder Disease		
Blurred Vision			Kidney Disease		
Ringing in your ears			Kidney Stones		
Lightheadedness			Urinary Tract Infection		
Difficulty Sleeping			Stomach Pains		
Arthritis			Nausea and/or Vomiting		
Leg Cramps			Loss of Appetite		
Back Pain			Gallbladder Disease		
Phlebitis/Blood Clots			Change in Bowel Habits		
Numbness in hands or feet			Diarrhea/Constipation		
Skin Lesions			Colitis		
Poor Hearing			Ulcer Disease		
Easy Bruising			Yellow Jaundice		
Family history of Cancer			Hepatitis		
DO YOU HAVE…….			DO YOU HAVE……..		
History of Smoking			History of Depression		
Number of packs per day:			History of Stress		
History of Alcohol			History of other Emotional Problems		
Number of drinks per day:			History of Anxiety		
History of Drug abuse					

Are you in any pain? Yes ☐ No ☐ Level 0-10_____ (0 = no pain; 10 = extreme pain)

Has your appetite changed in the last three months? Yes ☐ No ☐

During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

Not at all☐ Very little ☐ Some what ☐ Quite a lot ☐ Could not do physical activities ☐

During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?

Not at all☐ Very little☐ Somewhat☐ Quite a lot ☐ Could not do physical activities ☐

Patient's Name:_____ Social Security Number:_____

MEDICATIONS-PLEASE PRINT NAMES OF MEDICATIONS AND DOSE:

Medication	Dose	Time

PLEASE LIST ALLERGIES TO MEDICATIONS:

Medication	Side Effect

PREVIOUS SURGERY INFORMATION:

Type of Surgery	Date

PREVIOUS MEDICAL HISTORY:

Medical Condition	Date of Onset

FAMILY MEDICAL HISTORY: (include all types of cancer)

Medical Condition	Family Member

Patient's Name:_____ Social Security Number:_____

PATIENT/PHYSICIAN INFORMATION (YOU MUST FILL OUT COMPLETELY)

Referring Physician or Primary Care Physician: _____

Address: _____

_____

Phone:_____ **Fax:**_____

Please list any other Physicians you currently see:

Physician Name: _____

Address/Phone: _____
_____

Physician Name: _____

Address/Phone: _____
_____

Physician Name: _____

Address/Phone: _____
_____

Physician Name: _____

Address/Phone: _____
_____

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Personal Representative Designation Form

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments. However, unless the personal representative is a licensed physician who is credentialed to provide healthcare services at UPMC, use of UPMC's internal electronic medical record systems to access such medical information is not permitted.

Note that this form is not applicable and cannot be used for UPMC behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to:

- Procedures/services that require informed consent (and withdrawal of consent if applicable);
- Admissions to and discharges from nursing homes or other long-term care facilities;
- Donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy;
- Continuation or withdrawal of life support; and
- For major health care decisions, a formal power of attorney or living will is required.

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Personal Representative Designation Form

This personal representative designation applies to the following UPMC entity/locations:

List all applicable entities:

_____

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:	Patient's Phone:
Patient's Address:		
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues your personal representative may discuss? Yes _____ No _____ If yes, please specify:		
Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).		

REQUIRED SIGNATURES:

Personal Representative Signature:_____Date: _____

Patient Signature: _____Date: _____

Please return this completed form by mail to: _____

_____

_____

or by fax to: _____

2REP

FORM # UPP-0750-0313

Your Chaperone at the UPMC Liver Cancer Center

We want to make your first visit with us as smooth and stress-free as possible. Please allow one of our chaperones from the UPMC Liver Cancer Center to meet you when you arrive, walk with you to the center, and help guide you through the process.

Where to Park

UPMC Montefiore Garage
(Entrance at 1 Buffalo St.)

- After you park, your chaperone will meet you at the UPMC Montefiore Information Desk on the 7th floor (Main Lobby), which can be seen from the garage.
- Your parking ticket will be validated for a reduced rate.

Kaufmann Medical Building Garage
(Entrance at 3471 Fifth Ave.)

- If the UPMC Montefiore Garage is full, you can park in this garage.
- After you park, your chaperone will meet you at the gray steel entrance door to the Kaufmann Building.
- Your parking ticket will be validated for a reduced rate.

When You Arrive

1. **As soon as you park, please call us at 412-522-4660.** Let us know which garage you parked in and what floor you are on.
2. **We will send a chaperone to meet you.** They will guide you to where you need to go.

Contact Information

UPMC Liver Cancer Center
3459 Fifth Ave, 7th Floor
Pittsburgh, PA 15213
412-522-4660
UPMC.com/LiverCancerCenter

Hours: 8 a.m. to 4:30 p.m. Monday through Friday

UPMC
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