PACIFIC BRAIN TUMOR CENTER

AT PROVIDENCE SAINT JOHN'S HEALTH CENTER

NEURO-ONCOLOGY AND NEUROTHERAPEUTICS

NEW PATIENT INFORMATION PACKET

Dear Patients and Caregivers:

Thank you for allowing us to be part of your care. In order to prepare for your visit as best as possible we have enclosed forms for you to fill out before your scheduled appointment. We also request some medical records, labs, and/or imaging items. They have been outlined in this checklist for your convenience. This information is vital to optimizing your visit. Please email these forms back (**Neuro.Oncology@JWCI.org**) or bring them with you to your appointment. You may turn in the forms at the clinic admissions desk upon your arrival.

Please be aware that your combined wait and visit time may vary due to the possibility of urgent and emergent patient care matters that arise suddenly throughout the clinic day. We appreciate your understanding. All co-pays for doctor visits, chemotherapy, or procedures will be collected at the time of the visit.

Also enclosed are our contact sheet and directions to our facility and clinic. We look forward to seeing you and please feel free to contact us with any questions or concerns 310-829-8265.

Done?	Document	Instructions
	New patient Intake form	Please fill out as completely as possible. Print, fill out, and bring with you to your appointment
	Authorization for Release of Tissue	If you have had surgery or biopsy, please print and sign the release form in the event tissue testing is required
	Authorization for Release of Medical Records	Please print and fill out completely.
	Distress Scale	Please mark which areas are of most concern to you
	Medical Records	
	Most Recent imaging (MRI, CT, Xray, etc)	Please bring imaging scans on CD or on film if they were obtained NOT at Saint John's Health Center
	Most recent lab tests (blood, urine, lumbar puncture, bone marrow biopsy, etc.)	Please bring results for any recent lab tests performed NOT at Saint John's Health Center
	Insurance	
	Medical Insurance cards	We will make copies of these at your appointment. ****For HMO insurance:** please be sure to bring your "Letter of Authorization" from your HMO. If your insurance is not accepted by our medical group, or if we do not have written authorization on file, you will be asked to sign a waiver stating that you will be financially responsible should the insurance company deny our claim.
	Day of Visit	
	Bring a family member or friend, pen, notebook	Some patients find it helpful to bring a family member or friend as well as pen/paper to take notes with.

Clinic address: 2121 Santa Monica Boulevard, Santa Monica, CA 90404
Mailing address & Administrative offices: 2020 Santa Monica Blvd CA 90404
Phone 310-829-8265 | Fax 310-582-7287 | www.pacificbraintumor.org

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AT PROVIDENCE SAINT JOHN'S HEALTH CENTER

NEURO-ONCOLOGY AND NEUROTHERAPEUTICS

NEW PATIENT INTAKE FORM

Today's Date ____/____/____

Patient Information

Last Name _____ First Name _____ Middle _____

Address _____ City _____State____ Zip_____

Birth Date___/___/_____ Sex: M ☐ F ☐ Home Phone _____

E-Mail_____ Cell Phone_____

Race _____ Preferred Language _____

Employer _____ Work Phone _____

Employer Address _____City _____State____Zip_____

Occupation_____Social Security # _____-_____-_____

Relative or Friend Contact information

(please indicate if we are able to release any or all info relating to your medical condition to the person listed below)

Name_____ Name_____

Relationship_____ Relationship_____

Phone_____ Med Release Y ☐ N ☐ Phone_____ Med Release Y ☐ N ☐

Physician Information

Primary Care Physician

Name _____

Phone _____

Address_____

_____

Neurosurgeon

Name_____

Phone_____

Address_____

_____

Neuro-Oncologist/Oncologist

Name_____

Phone_____

Address_____

_____

Radiation Oncologist

Name_____ _____

Phone_____

Address_____

_____

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Patient Name_____

Reason for Visit: ☐ Establishing Care ☐ Second Opinion

How did you hear about us?

☐ Referring Doctor (name) _____

☐ Family/Friend ☐ Internet ☐ Health Fair ☐ Other_____

Reason for Visit/Diagnosis_____Date of Diagnosis____/____/_____

Treatment History (provide information specific to your visit diagnosis)

Surgical History

Type of Surgery & reason for surgery	Location of Surgery (Hospital)	Date of Surgery

Radiation History

Radiation location (on body)	Location of Radiation (Hospital)	Start Date – End Date

Chemotherapy and/or Medication History used to treat this diagnosis

(please include any devices, alternative therapies, research trials, etc.)

Medication	Dose (mg)	Frequency (daily/weekly)	Start Date – End Date

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GENERAL HEALTH & MEDICAL HISTORY & DISCLOSURE

Patient Name_____

Past Medical History (please check all that apply and indicate date of diagnosis)

☐	Asthma:
☐	Anemia:
☐	Blood Clots:
☐	Colon Polyps:
☐	Emphysema:
☐	High Blood Pressure:
☐	Kidney Disease:
☐	Prostate Disease:
☐	Stroke:
☐	Other:

☐	Autoimmune Disorder:
☐	Brain Tumor:
☐	Blood Transfusion:
☐	Diabetes:
☐	Heart Disease:
☐	Jaundice/Cirrhosis:
☐	Menopause:
☐	Seizures:
☐	Thyroid Disease:
☐	Other:

Other than your diagnosis listed on Page 2, have you ever been treated for any other cancers before? Please explain.

_____

Other than those listed on Page 2, have you had any other prior surgeries? Please list.

Type of Surgery & reason for surgery	Location of Surgery (Hospital)	Date of Surgery

Female Patients Only

Are you Pregnant? ☐ Yes ☐ No Age of 1st Menstrual Cycle _____ Age of last menstrual Cycle _____

Have you ever used estrogen? ☐ Yes ☐ No If yes, for how long? _____

Have you ever used birth control? ☐ Yes ☐ No If yes, for how long?_____ Type_____

# of pregnancies_____ Age of 1st pregnancy _____ # of children_____

Hysterectomy? ☐ Yes ☐ No Ifyes, type of surgery & date _____

Social History

Marital Status(circle one): Married / Single / Widowed / Divorced # of Children (Male)_____ (Female)_____

Who do you live with?_____

Alcohol use? ☐ Yes ☐ No #drinks____ per (day/week/mo)_____Years of use_____

Tobacco use? ☐ Yes ☐ No packs per day_____ Years of use_____ Former Smoker ☐ Yes #Yrs_____

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FAMILY HEALTH AND MEDICAL HISTORY

Patient Name_____

Please list major health problems your family has experienced

Are you adopted? ☐ Yes Are you a twin? ☐ Yes

Relative	Deceased & living?	Significant Medical History (blood pressure, heart disease, cancer, etc.)
Mother		
Father		
Sister		
Sister		
Brother		
Brother		

MEDICATIONS

Preferred Pharmacy_____Phone_____

Address_____

Please list all medications you are currently taking, dose, and frequency

Medication Name	Dose	Frequency (daily/weekly/as needed/etc)	Start date – End Date

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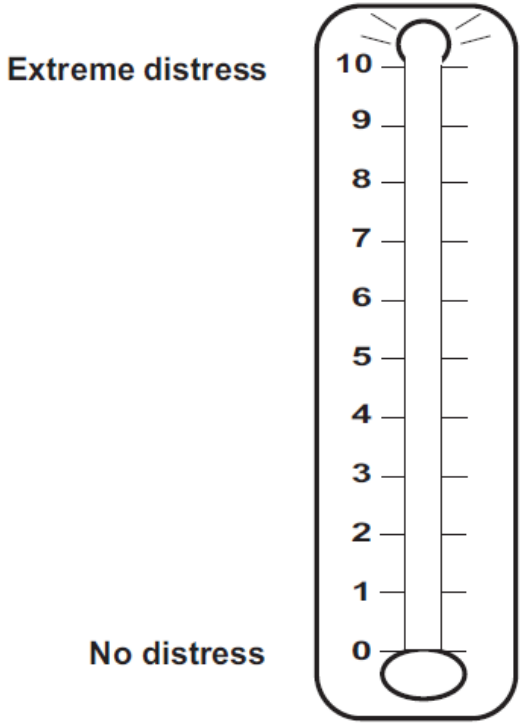
DISTRESS SCREEN

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Patient label

Staff Only:
DS administered by
Signed: _____
DS reviewed by
Signed: _____Date:_____

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

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Santosh Kesari, MD, PhD, FANA, FAAN
Chair, Department of Translational Neuro-Oncology and Neurotherapeutics

AUTHORIZATION FOR RELEASE OF PARAFFIN EMBEDDED TISSUE BLOCKS OR PARAFFIN SECTIONS MOUNTED ON ADHESIVE SLIDES

Please accept this as notification that I, _____, am requesting the release of formalin fixed, paraffin embedded tissue specimens in the form of one or more whole paraffin blocks or Paraffin sections mounted on Adhesive slides obtained from biopsies or procedures performed at your healthcare facility to _____. This request is being made for the purposes of analysis that will provide information that may aid in chemotherapy treatment decisions for my **continued patient care**. I also authorize the release of all corresponding final pathology reports for the specimens to be analyzed.

INSTITUTION INFORMATION	
Institution/Hospital Name	
Pathologist	NPI/UPIN
Preferred Dept. Contact	
Phone #	
HIPAA Compliant Fax#	

PATIENT INFORMATION
Patient Name
Patient SS# Or Patient MR#
Date of Birth
Gender
Primary Tumor Type

SIGNATURES		
Requesting Physician Signature	Phone #	Date
Patient Signature (if required by hospital)		Date

SPECIMEN INFORMATION	
Specimen Collection Date	Accession #

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)

Name:_____ DOB:_____

SSN:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Please Release My Records From

NAME:_____

TELEPHONE:_____

FAX:_____

TO OUR MAILING ADDRESS:
Santosh Kesari, MD, PhD, FANA, FAAN
2200 Santa Monica Blvd
Santa Monica, CA 90404
Phone: 310-829-8265
Fax: 310-582-7287

Please send these medical records no later than _____
(DATE)

Please release a copy of my records, including progress notes, operative notes, laboratory results, imaging reports (e.g., MRI and CT), diagnostic tests and pathology reports.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO:
SANTOSH KESARI, MD, PhD, FANA, FAAN

SIGNATURE:_____ DATE:_____

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DR. SANTOSH KESARI'S OFFICE CONTACTS

Hours of Operation: Monday-Friday 8:00 a.m. - 5:00p.m. (Closed Holidays and Weekends)
Infusion Center Hours: Monday-Friday 8:00 a.m. - 3:00 p.m.

Resource	Name	Phone	Fax
Administrative Associates	Selenia Claros Shelly Trujillo	(310) 829-8265	(310) 582-7287
**For assistance with scheduling and general questions* ***Please call prior to coming in to pick up forms or letters to insure their availability as they take 24-48 hrs to prepare* ****For medication refills please have your pharmacy fax a request to the fax number above*			
Physician Assistants	Judy Truong, PA-C Minh Nguyen, PA-C	(310) 829-8265	(310) 582-7287
Social Workers	Lind Roberts, LCSW Lauren Small, LCSW	(310) 829-8524 (310) 829-8544	(310) 582-7029
**For assistance in finding support groups, community resources, psycho-social support, etc.*			
Financial/Billing Services	Mia & Michelle	(310) 582-7254 or (310) 582-7270	
Clinical Trials	Najee Boucher (Clinical Research Coordinator) Annie Heng, RN, BSN (Clinical Research Nurse)	(310) 582-7460 (310) 582-7457	(310) 582-7287
MRI Location	Tower St Johns Imaging Dept. Scheduling 2202 Wilshire Blvd. Santa Monica, CA 90403	(310) 264-9000	

MyChart

After your visit, you will receive instructions on how to sign up for MyChart. This is a tool where you can access your lab results, communicate with your care team, ask for medication refills, and it is all protected for your privacy. We encourage you to sign up as soon as you obtain an access code after your visit. This is the easiest way to get in touch with your care team.

http://mychartor.providence.org/mychart

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NEURO-ONCOLOGY AND NEUROTHERAPEUTICS

DIRECTIONS

Conveniently located near the corner of Santa Monica Blvd and 20th Street in Santa Monica, Providence Saint John's Health Center is easily accessible from all points in Southern California. It is approximately 15 miles from Los Angeles International Airport. Patient drop off/valet parking is located on Santa Monica Blvd in front of the hospital. Valet parking (including handicapped parking) is $13.00. We unfortunately cannot validate parking.

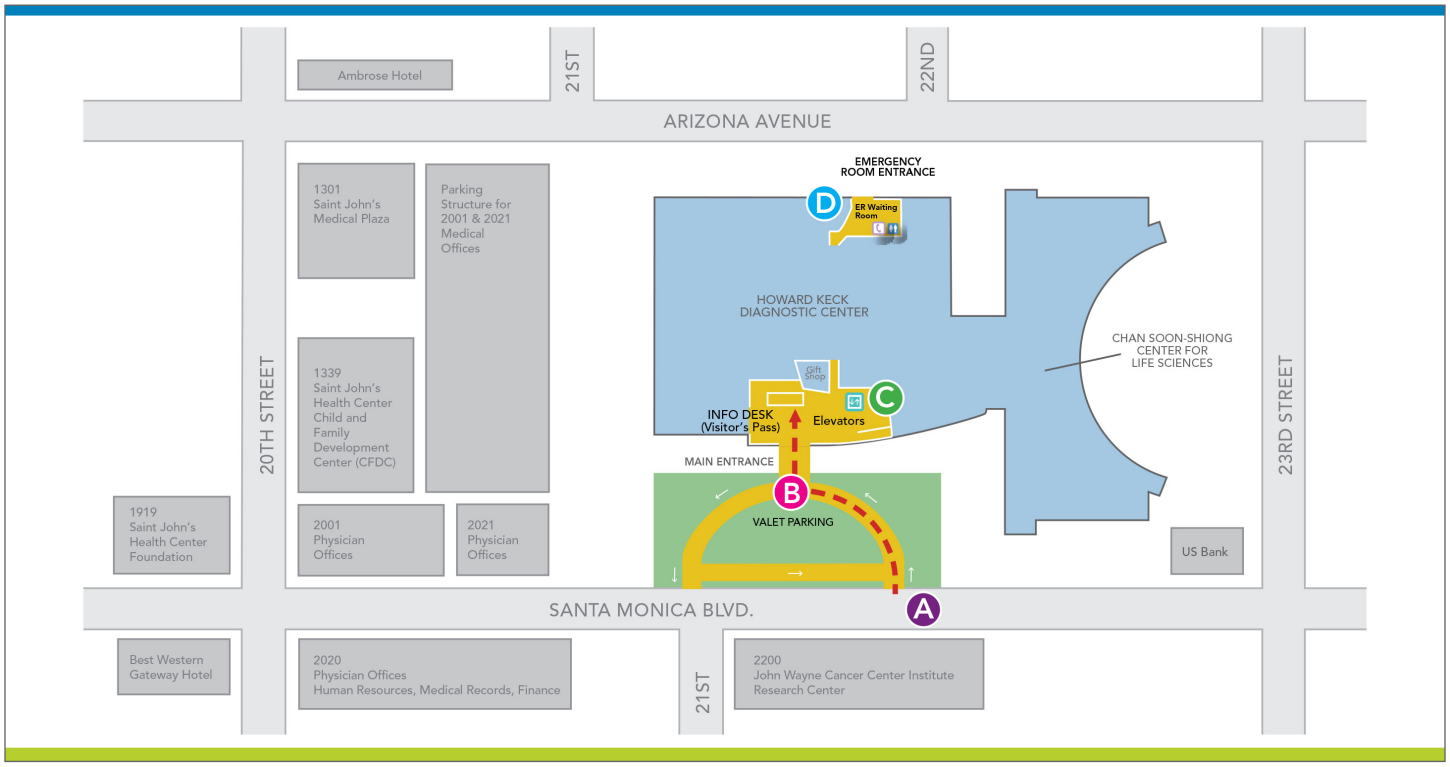
Coming from NORTH of Santa Monica: Take 405 South to the 10 West

Coming from SOUTH of Santa Monica: Take 405 North to the 10 West

Coming from EAST of Santa Monica: Take the 10 West and exit RIGHT (north) onto Cloverfield Blvd then turn LEFT (west) onto Santa Monica Blvd

Coming from WEST of Santa Monica on Pacific Coast Highway: Take the 10 East and exit LEFT (north) onto 20th Street then turn RIGHT (east) onto Santa Monica Blvd

A. Providence Saint John's Health Center is on the north side of the street at 2121 Santa Monica Blvd.
B. Park with the valet and proceed through the main entrance into the Howard Keck Center.
C. Take the Howard Keck elevators down to the Garden Level (GL) to the Cancer Center Reception Desk.
D. Please note that the main entrance is open from 5:00 am – 8:30 pm. During other hours, use the **Emergency Room Entrance** located on Arizona Blvd.



For assistance finding your way in the Health Center, please feel free to call our office at 310-829-8265.

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