NJU CANCER TREATMENT CENTERS
Excellence In Care

RADIATION ONCOLOGY
ACR AMERICAN COLLEGE OF RADIOLOGY
ACCREDITED FACILITY

Dear Patient,

We have arranged a consultation appointment at NJU Cancer Treatment Centers, 2090 Springdale Road, Suite B, Cherry Hill, NJ 08003.

For your initial consultation, please be sure to bring your driver's license (or any legal form of identification), your insurance cards and any co-pay/co-insurance that is due at the time of consultation.  Also, if you have an Advance Directive (Living Will), please bring a copy for our records.

These documents are needed for your consultation.  Please download, complete these forms and bring them with you on the day of your appointment.

Please do not hesitate to call us at **(856) 751-9010** if you have any questions or need further information.

Respectfully yours,
NJU Cancer Treatment Centers

PATIENT AUTHORIZATION FORM

Patient Name: ______________________________ MR#:____________*(office use only)*

Date of Birth: ______________________

## Payment Authorization

I hereby authorize my benefits to be paid directly to NJU Cancer Treatment Centers and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

Signature: ___________________________________________ Date: ____________

## Acknowledge Receipt of Privacy Practice

I have been offered a copy of the NJU Cancer Treatment Centers Notice of Privacy Practices. I understand that NJU Cancer Treatment Centers has the right to change its Notice of Privacy Practices from time to time and that I may contact NJU Cancer Treatment Centers at any time to obtain a current copy of the Notice of Privacy Practices.

Signature: ___________________________________________ Date: ____________

Copy Declined Copy Accepted ☐

## Release of Health Information

I authorize the following individual(s) to have access to my personal health information.

Name:______________________ Relationship:____________________________

Signature: ___________________________________________ Date: _____________

## Patient Bill of Rights

I have been offered a copy of the Patients Bill of Rights. I understand that I may contact NJU Cancer Treatment Centers at any time to obtain a current copy of the Patient Bill of Rights.

Signature: ___________________________________________ Date: ________________

Copy Declined ☐ Copy Accepted ☐

NJU CANCER TREATMENT CENTERS
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# NEW PATIENT INFORMATION FORM

Patient Name: ________________________ DOB: _____/______/_____
Address: __________________________ Age: _________
__________________________
__________________________ Email: ___________________________________
MR#: _____________(office use only) May we contact you via email: ☐ Yes ☐ No

Home Phone______________________May we leave a message? ☐Yes /☐ No
Mobile Phone_____________________May we leave a message? ☐Voicemail ☐ Text Message ☐ Non
Mobile Phone Provider______________________________________________
Work Phone ______________________ May we leave a message? ☐Yes /☐ No
Emergency Contact (Name, Phone# & Relationship)__________________________________________
Advance Directive (Living Will) ☐ Yes (please provide a copy) ☐ No ☐ Would Like Information
Referring Urologist: <Primary Referring Physician> Primary Cary Physician:__________________
Race:______________ Ethnicity: ____________________ Preferred Language:___________________________

## HISTORY OF PRESENT ILLNESS

Cancer Diagnosis:_______________________________________________________________________________________

## MEDICAL HISTORY

PREVIOUS HOSPITALIZATION / SURGERIES / HIP REPLACEMENT / SERIOUS INJURIES – When? ________________
_______________________________________________________________________________________________

Anesthesia History ☐ Uneventful ☐ Other

**PREVIOUS RADIATION THERAPY** ☐ **YES** ☐ **NO (**If yes please provide dates and location):
_______________________________________________________________________________________

**PREVIOUS CHEMOTHERAPY** ☐ **YES** ☐ **NO** (if yes, please provide dates):
_______________________________________________________________________________________

**PATIENT SOCIAL HISTORY** **Occupation**:_______________________ ☐ Retired

| Marital Status | Use of Alcohol | Use of Tobacco | Use of Illicit Drugs | Excessive Exposure at Home or Work to: |
|---|---|---|---|---|
| ☐Single | ☐Never | ☐Never | ☐Never | ☐Fumes___________ |
| ☐Married | ☐Rarely | ☐Previous but Quit | ☐Type & Frequency | ☐Solvent___________ |
| ☐Divorced | ☐Moderate | ☐Currently | _____________ | ☐Chemicals_________ |
| ☐Widowed | ☐Daily | _____packs daily | ______________ | ☐Other____________ |

## FAMILY MEDICAL HISTORY

| | AGE | DISEASES | IF DECEASED, CAUSE OF DEATH |
|---|---|---|---|
| FATHER | _____ | ______________________________ | ___________________________ |
| MOTHER | _____ | ______________________________ | ___________________________ |
| BROTHERS | _____ | ______________________________ | ___________________________ |
| | _____ | ______________________________ | ___________________________ |
| SISTERS | _____ | ______________________________ | ___________________________ |
| | _____ | ______________________________ | ___________________________ |
| SPOUSE | _____ | ______________________________ | ___________________________ |
| CHILDREN | _____ | ______________________________ | ___________________________ |

**NEW PATIENT INFORMATION FORM**

# SYSTEM REVIEW

Patient Name: ____________________ D/O/B:___/___/_____ MR#:____________*(office use only)*

## 1) RESPIRATORY

| | | |
|---|---|---|
| Chronic or Frequent Cough | ☐Yes | ☐No |
| Spitting up Blood | ☐Yes | ☐No |
| Shortness of Breath | ☐Yes | ☐No |
| Asthma or Wheezing | ☐Yes | ☐No |
| Tuberculosis | ☐Yes | ☐No |
| Recent Upper Respiratory Infection | ☐Yes | ☐No |
| Sleep Apnea | ☐Yes | ☐No |

## 2) PSYCHIATRIC

| | | |
|---|---|---|
| Memory Loss or Confusion | ☐Yes | ☐No |
| Nervousness | ☐Yes | ☐No |
| Depression | ☐Yes | ☐No |
| Insomnia | ☐Yes | ☐No |

## 3) EYES

| | | |
|---|---|---|
| Eye Disease or Injury | ☐Yes | ☐No |
| Wear Glasses / Contact Lenses | ☐Yes | ☐No |
| Blurred or Double Vision | ☐Yes | ☐No |
| Glaucoma | ☐Yes | ☐No |

## 4) HEMATOLOGIC/LYMPHATIC

| | | |
|---|---|---|
| Slow to Heal After Cuts | ☐Yes | ☐No |
| Bleeding or Bruising Tendency | ☐Yes | ☐No |
| Anemia | ☐Yes | ☐No |
| Phlebitis | ☐Yes | ☐No |
| Past Transfusion | ☐Yes | ☐No |
| Enlarged Glands | ☐Yes | ☐No |
| Blood Transfusions | ☐Yes | ☐No |
| Transfusion Reactions | ☐Yes | ☐No |

## 5) CONSTITUTIONAL SYMPTONS

| | | |
|---|---|---|
| Good General Healthy Lately | ☐Yes | ☐No |
| Recent Weight Change | ☐Yes | ☐No |
| Fever | ☐Yes | ☐No |
| Fatigue | ☐Yes | ☐No |
| Headaches | ☐Yes | ☐No |
| Insomnia | ☐Yes | ☐No |
| Hours of Sleep Each Night | ____________ | |
| Communicable Disease | ☐Yes | ☐No |
| HIV | ☐Yes | ☐No |

## 6) CARDIOVASCULAR

| | | |
|---|---|---|
| Heart Trouble | ☐Yes | ☐No |
| Chest Pains | ☐Yes | ☐No |
| Angina Pectoris | | |
| Palpitations | ☐Yes | ☐No |
| Shortness of Breath while Walking or Lying | ☐Yes | ☐No |
| Swelling of Feet or Ankles | ☐Yes | ☐No |
| **Pacemaker/Defibrillator** | ☐Yes | ☐No |
| Myocardial Infarction | ☐Yes | ☐No |
| Hypertension | ☐Yes | ☐No |
| Heart Failure | ☐Yes | ☐No |
| Valve Disease | ☐Yes | ☐No |
| Heart Murmur | ☐Yes | ☐No |
| Irregular Rhythm | ☐Yes | ☐No |
| High Cholesterol | ☐Yes | ☐No |
| Peripheral Vascular Disease | ☐Yes | ☐No |

## 7) MUSCULOSKELETAL

| | | |
|---|---|---|
| Arthritis | ☐Yes | ☐No |
| Joint Pain | ☐Yes | ☐No |
| Joint Stiffness or Swelling | ☐Yes | ☐No |
| Weakness of Muscles/Joints | ☐Yes | ☐No |
| Muscle Pain or Cramps | ☐Yes | ☐No |
| Muscular Disorder | ☐Yes | ☐No |
| Back Pain | ☐Yes | ☐No |
| Cold Extremities | ☐Yes | ☐No |
| Difficulty in Walking | ☐Yes | ☐No |
| Spine Disease | ☐Yes | ☐No |
| Fractures | ☐Yes | ☐No |

## 8) INTEGUMENTARY

| | | |
|---|---|---|
| Rash or Itching | ☐Yes | ☐No |
| Change in Skin Color | ☐Yes | ☐No |
| Change in Hair or Nails | ☐Yes | ☐No |
| Varicose Veins | ☐Yes | ☐No |
| Breast Pains | ☐Yes | ☐No |
| Breast Lump | ☐Yes | ☐No |
| Breast Discharge | ☐Yes | ☐No |
| Skin Disorders | ☐Yes | ☐No |

## 9) ENDOCRINE

| | | |
|---|---|---|
| Glandular/ Hormone Problems | ☐Yes | ☐No |
| Thyroid Disease | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No |
| Excessive Thirst or Urination | ☐Yes | ☐No |
| Heat or Cold Intolerance | ☐Yes | ☐No |
| Skin Becoming Dryer | ☐Yes | ☐No |
| Change in Hat or Glove Size | ☐Yes | ☐No |

## 10) EARS, NOSE, MOUTH & THROAT

| | | |
|---|---|---|
| Hearing Loss or Ringing | ☐Yes | ☐No |
| Hearing Aids | ☐Yes | ☐No |
| Earaches or Drainage | ☐Yes | ☐No |
| Chronic Virus Problems/Rhinitis | ☐Yes | ☐No |
| Nose Bleeds | ☐Yes | ☐No |
| Mouth Sores | ☐Yes | ☐No |
| Bleeding Gums | ☐Yes | ☐No |
| Bad Breath or Bad Taste | ☐Yes | ☐No |
| Sore Throat or Voice Change | ☐Yes | ☐No |
| Swollen Glands in Neck | ☐Yes | ☐No |
| Difficulty Swallowing | ☐Yes | ☐No |

## 11) NUTRITION

| | | |
|---|---|---|
| Supplements | ☐Yes | ☐No |
| Tube Feed | ☐Yes | ☐No |
| TPN | ☐Yes | ☐No |
| Eating Disorders | ☐Yes | ☐No |
| Vitamin/Mineral /Herbals | ☐Yes | ☐No |
| Liver Failure | ☐Yes | ☐No |
| Difficulty Swallowing | ☐Yes | ☐No |
| Unintentional Weight Loss In 3 months | ☐Yes | ☐No |

## System Review (cont.)

Patient Name: ____________________ D/O/B:___/___/_____ MR#:____________*(office use only)*

### 12) GASTROINTESTINAL

- Loss of Appetite ☐Yes ☐No
- Change in Bowel Movements ☐Yes ☐No
- Nausea or Vomiting ☐Yes ☐No
- Frequent Diarrhea ☐Yes ☐No
- Painful Bowel Movements or Constipation ☐Yes ☐No
- Rectal Bleeding or Blood in Stool ☐Yes ☐No
- Abdominal Pain or Heartburn ☐Yes ☐No
- Peptic Ulcer (Stomach or Duodenal) ☐Yes ☐No
- Hiatus Hernia ☐Yes ☐No
- Gastrointestinal Problems ☐Yes ☐No
- Hemorrhoids ☐Yes ☐No
- Pancreatitis ☐Yes ☐No
- Hepatitis ☐Yes ☐No
- Liver Disease ☐Yes ☐No
- Renal Disease ☐Yes ☐No

**Colonoscopy** ☐Yes ☐No
________________(Month / Year)
Most Recent

**Flu Shot** ☐Yes ☐No
________________(Month / Year)
Most Recent

**Pneumonia Vaccine** ☐Yes ☐No
________________(Month / Year)
Most Recent

Physician Signature________________________

Date: ____________ *(office use only)*

### 13) NEUROLOGICAL

- Frequent or Recurring Headaches ☐Yes ☐No
- Light Headed or Dizzy ☐Yes ☐No
- Convulsions or Seizures ☐Yes ☐No
- Numbness or Tingling Sensation ☐Yes ☐No
- Tremors ☐Yes ☐No
- Weakness or Paralysis ☐Yes ☐No
- Stroke ☐Yes ☐No
- Head Injury ☐Yes ☐No
- Speech Difficulties ☐Yes ☐No
- Change in Gait ☐Yes ☐No
- Vision Difficulties ☐Yes ☐No
- Glasses / Contact Lenses ☐Yes ☐No

### 14) GENITOURINARY

- Frequent Urination ☐Yes ☐No
- Burning or Painful Urination ☐Yes ☐No
- Blood in Urine ☐Yes ☐No
- Change in Force of Stream when Urinating ☐Yes ☐No
- Incontinence or Dribbling ☐Yes ☐No
- Kidney Stones ☐Yes ☐No
- Sexually Transmitted Diseases ☐Yes ☐No

### 15) RISK ASSESSMENT

- Have you fallen in the past year? ☐Yes ☐No
- Do you feel unsteady when standing or walking? ☐Yes ☐No
- Do you worry about falling? ☐Yes ☐No

Have you lived in or traveled to a country with widespread Ebola virus transmission or had contact with an individual with confirmed Ebola Virus Disease within the previous 21 days? No_____ Yes_____ Initials_____

PHYSICIAN INFORMATION

Patient Name: ________________________________ MR# :___________*(office use only)*

Date of Birth: _____/______/_______

Please inform us of all physicians you are currently seeing:

| **Referring Physician Name:** | | |
|---|---|---|
| **Specialty: Urology** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Tel# (     )☐☐☐ - ☐☐☐☐** | **Fax: (     )☐☐☐-☐☐☐☐** | |

| **Physician Name:** | | |
|---|---|---|
| **Specialty: Primary Care** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Tel# (     )☐☐☐ - ☐☐☐☐** | **Fax: (     )☐☐☐-☐☐☐☐** | |

**PHARMACY INFORMATION**

| **Name of Pharmacy:** | | |
|---|---|---|
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Tel# (     )☐☐☐ - ☐☐☐☐** | **Fax: (     )☐☐☐-☐☐☐☐** | |

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# International Prostate Symptom Score (IPSS)

| Name: ____________________<br>Date of Birth: ______/______/______<br>MR#:__________ *(office use only)*<br>Date: ________________ | Not at all | Less than 1 time in 5 | Less than half the time | About half the time | More than half the time | Almost always | **Your score** |
|---|---|---|---|---|---|---|---|
| Incomplete emptying<br>Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Frequency<br>Over the past month, how often have you had to urinate again less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Intermittency<br>Over the past month, how often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Urgency<br>Over the last month, how difficult have you found it to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Weak stream<br>Over the past month, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Straining<br>Over the past month, how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 | |

| | None | 1 time | 2 times | 3 times | 4 times | 5 times or more | **Your score** |
|---|---|---|---|---|---|---|---|
| Nocturia<br>Over the past month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Total IPSS score → | | | | | | | |

| Quality of life due to urinary symptoms | Delighted | Pleased | Mostly satisfied | Mixed – about equally satisfied and dissatisfied | Mostly dissatisfied | Unhappy | Terrible |
|---|---|---|---|---|---|---|---|
| If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

**Total score:** 0-7 mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

NJU CANCER TREATMENT CENTERS

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ED EVALUATION FORM

Patient Name: ____________________
Date of Birth: ______/_____/_________
MR#:___________(office use only)

## PLEASE INDICATE (CIRCLE) THE APPROPRIATE NUMBERS BELOW

| | | | | | | |
|---|---|---|---|---|---|---|
| 1) How do you rate your confidence that your could get and keep an erection? | | 1 VERY LOW | 2 LOW | 3 MODERATE | 4 HIGH | 5 VERY HIGH |
| 2) When you had erections with sexual stimulations, how often were your erections hard enough for penetration? | 0 NO SEXUAL ACTIVITY | 1 ALMOST NEVER | 2 A FEW TIMES | 3 SOMETIMES | 4 MOST TIMES | 5 ALMOST ALWAYS |
| 3) During sexual intercourse, how often were you able to maintain your erection? | 0 DID NOT ATTEMPT INTERCOURSE | 1 ALMOST NEVER | 2 A FEW TIMES | 3 SOMETIMES | 4 MOST TIMES | 5 ALMOST ALWAYS |
| 4) During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse | 0 DID NOT ATTEMPT INTERCOURSE | 1 EXTREMELY DIFFICULT | 2 VERY DIFFICULT | 3 DIFFICULT | 4 SLIGHTLY DIFFICULT | 5 NOT DIFFICULT |
| 5) When you attempted sexual intercourse, how often was it satisfactory? | 0 DID NOT ATTEMPT INTERCOURSE | 1 ALMOST NEVER | 2 A FEW TIMES | 3 SOMETIMES | 4 MOST TIMES | 5 ALMOST ALWAYS |
| 6) How would you rate your ejaculate (fluid that comes out with an orgasm? | NORMAL | LESS THAN NORMAL | NONE | | | |

NJU CANCER TREATMENT CENTERS
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# PATIENT MEDICATION LIST

Today's Date: ____________

Patient Name: ________________________ D/O/B:___/___/_____ MR#:___________*(office use only)*

Form completed by:________________Relationship to Patient:_____________Contact #: ________________

| | **NAME** | **PHONE** |
|---|---|---|
| **PRIMARY DOCTOR** | | |
| **PHARMACY** | | |
| Please check one box: ☐ Pills | ☐ Liquid medication only | |

| ALLERGIES: Medication, Food, Environmental | ALLERGIC REACTION: (hives, redness, itching) |
|---|---|
| | |
| | |

**FLU SHOT:** ☐ **YES** ☐ **NO** (if yes, please provide date of most recent)______________________________

**MEDICATIONS:** (IF YOU NEED MORE SPACE REGARDING ALLERGIES & MEDICATIONS, PLEASE CONTINUE ON THE BACK OF THIS FORM)

☐ I am currently not taking any medications at home.

| NAME OF **HOME** MEDICATIONS (include prescriptions, over-the-counter meds, herbal supplements, patches, inhalers, eye drops, vitamins) | DOSE (mg, units, puffs, drops) | ROUTE (by mouth, patch) | FREQUENCY (how often do you take it) | DATE & TIME OF LAST DOSE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Physician Signature | | | Date: | |

**Patient Instructions:**

**Take All your medications as prescribed by your physician. Keep a list of your medications with you.**
**Contact your primary physician before taking any medications you have at home that are not on this list.**
**Contact your physician or pharmacist before taking any over-the-counter or herbal medications**
**Contact your physician or pharmacist about how to store your medications or how to dispose of and medications that are out of date or are no longer being taken.**

| NEW MEDICATION **(for office use only)** | DOSE | ROUTE | FREQUENCY | Reconciled with current medications | Continue Med after RT treatments? |
|---|---|---|---|---|---|
| | | | | | YES / NO |
| | | | | | YES / NO |
| | | | | | YES / NO |
| Comments: | | | | | |
| Patient Signature | | Date | | | |
| Physician Signature | | Date | RN Signature | | Date |

# NJU CANCER TREATMENT CENTERS

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO CLINIC

PATIENT: ___________________________MR# :_____________ *(OFFICE USE ONLY)*

DATE OF BIRTH: ____/____/______

I hereby authorize the staff of _________________________________to disclose my health information to:

NJU Cancer Treatment Centers
2090 Springdale Rd. Suite B
Cherry Hill, NJ 08003
Phone: 856-751-9010
Fax: 856-751-3243

The above named patient is being treated at NJU Cancer Treatment Centers and this information is needed as soon as possible for continuing medical care.

This authorization is limited to the following dates of treatment: FROM:_____ TO ______

Information to be disclosed:

☐ **OPERATIVE REPORTS** ☐ **PATHOLOGY REPORTS**
☐ **X-RAYS, CT SCANS, MRI REPORTS** ☐ **RADIATION THERAPY RECORDS**
☐ **OTHER** _________________

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, AIDS and HIV, SEXUALLY TRANSMITTED, TUBERCULOSIS and other INFECTIOUS DISEASE information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Radiation Oncology department. I understand the revocation will not apply to the extent that the NJU Cancer Treatment Centers has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition: ___________________________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Radiation Oncology at (856) 751-9010.

Patient Signature:_________________________________________________ Date: ____________
If legal representative, sign below and state relationship and authority to do so and attach the document of the authority.

Legal Representative: ______________________________________________________ Date: ____________

Relationship: ____________________________________________________________

Witness: ________________________________________________________________ Date: ____________