NJU CANCER TREATMENT CENTERS
Excellence In Care

Dear Patient;

We have scheduled you for an appointment with at NJU Cancer Treatment Centers to discuss your treatment options which will include, but not limited to radiation therapy.

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 (973) 873-7000 option 4 then option 1 if you have any questions or need further information. For directions to the specific location of your appointment please visit https://www.njurology.com/contact-us/locations/

Respectfully yours,
NJU Cancer Treatment Centers

NJU CANCER TREATMENT CENTERS
Excellence In Care

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
Excellence In Care

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 ☐ None
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:_____

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_____
Glen Gejerman, M.D.

Date: _____ Page 3 of 3

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_____

For Office Use Only:

Height _____
Weight _____
Temp. (F) _____
Pulse _____
Respiration _____
Systolic BP _____
Diastolic BP _____
O2 Sat (%) _____
Pain Assessment Score:_____

NJU CANCER TREATMENT CENTERS
Excellence In Care

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: ( )**☐☐☐-☐☐☐☐

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

PHARMACY INFORMATION

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

NJU CANCER TREATMENT CENTERS
Excellence In Care

International Prostate Symptom Score (IPSS)

Name: _____ Date of Birth: _____/_____/_____ MR#: _____(office use only) 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 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 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 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 Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining 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 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.

NJUCANCER TREATMENT CENTERS
Excellence In Care

ED EVALUATION FORM

Patient Name: _____ MR#_____*(office use only)*

Date of Birth: _____/_____/_____

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
Excellence In Care

PATIENT MEDICATION LIST

Today's Date:_____

Your Name: _____ Date of Birth: _____/_____/_____ 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: _____ MRN: #_____ *(OFFICE USE ONLY)*

DATE OF BIRTH: _____/_____/_____

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

NJU Cancer Treatment Centers
Attn: Dr. Glen Gejerman
160 Pehle Avenue Suite 103
Saddle Brook, NJ 07663
Phone: 201-881-1000
Fax: 201-226-0398

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 (973)873-7000.

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: _____