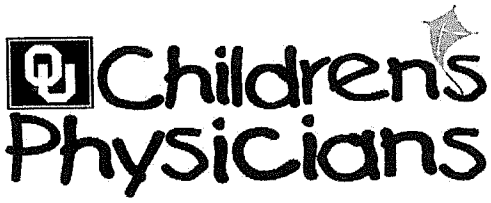

Pediatric Neurosurgery
1200 Children's Ave, Suite 7E
Oklahoma City, OK 73104
(405) 271-2244 Fax: (405) 271-4921

HISTORY OF CURRENT PROBLEM

We know that this is a long and detailed form to complete. Please understand that the quality of your care is dependent on a complete and thorough history. If you desire, we will cheerfully photocopy this form for you to provide to your other physicians or to keep for your own records. Please feel free to request a copy from the receptionist. All information is strictly confidential.

Patient: _____ DOB: ____/____/____ SEX: M / F

PCP: _____ Referring Physician: _____

Main complaint and symptoms (Describe what hurts and where): _____

_____

When did this problem FIRST START? _____

Are the problems related to an accident or injury? YES / NO If yes, date: _____

Please describe _____

Have you consulted other doctors? YES / NO

If yes, what has been done?

Dr. _____ Treatment: _____

Dr. _____ Treatment: _____

Dr. _____ Treatment: _____

Does anyone else in your family have similar problems? _____

_____

Father's Name: _____ Age: _____

Mother's Name: _____ Age: _____

Sibling's Names / Ages: _____

Was child adopted? YES / NO

Patient: _____ Date of Birth: ____/____/____

CURRENT MEDICATIONS

MEDICATION	DOSAGE	TAKEN HOW OFTEN?

ALLERGIES:

MEDICATION	ALLERGY	REACTION

HEALTH PROBLEMS

	PROBLEM	DATE CONDITION BEGAN	DATE CONDITION RESOLVED
1			
2			
3			
4			

HOSPITALIZATIONS

	REASON FOR HOSPITALIZATION	DATE	HOSPITAL
1			
2			
3			
4			

SURGERIES

	TYPE OF SURGERY	DATE	HOSPITAL
1			
2			
3			

Patient: _____ Date of Birth: ____/____/____

MOTHER'S HISTORY

Number of Pregnancies: _____ Number of Live Births: _____

Medical Problems: _____

_____

Medications: _____

_____

Drug Allergies: _____

Alcohol Use: During Pregnancy: YES / NO Currently: YES / NO

Tobacco Use: During Pregnancy: YES / NO Currently: YES / NO

LABOR & DELIVERY: Please complete Labor & Delivery section (if known)

Labor: Length of Labor (hours): _____ Induced? YES / NO

If yes, why? _____

Positive for Group B Strep during pregnancy? YES / NO

Treated for Group B Strep during pregnancy? YES / NO

Delivery: ☐ Vaginal ☐ Caesarean

If C-section, why? _____

Forceps? YES / NO Breech? YES / NO

Length of pregnancy at delivery? ☐ Full term (37-40 weeks) ☐ Premature (36 weeks or less)

☐ Post-term (> 40 weeks) (Preemie: Weeks _____ Days: _____)

If premature, original due date: _____

Birth Weight: _____ Birth Length: _____ Hospital Discharge Weight: _____

Apgar Score at 1 minute: _____ at 5 minutes: _____

Was baby in Neonatal Intensive Care? YES / NO If yes, how long? _____

Was baby ventilated? YES / NO

Did infant go home with mom? YES / NO

If no, how long did baby stay in nursery and why? _____

Any birth defects? YES / NO

Labor or Delivery problems or complications: _____

_____

Patient: _____ Date of Birth: ____/____/____

CHILDHOOD

Child lives with: _____

Attends daycare: YES / NO

Any hearing problems? YES / NO

Secondhand smoke exposure? YES / NO

Any vision problems? YES / NO

FAMILY HISTORY (Check all that apply)

	Father	Mother	Sibling 1	Sibling 2
Birth Defects				
Chromo-somal Defects				
Obesity				
Cancer				
Congenital Hearing Loss				
Mental Retardation				
Migraine Headaches				
Asthma				
Cystic Fibrosis				
Diabetes				
Metabolic or Endocrine Disease				
Blood Disorders (anemia, hemophilia)				
Seizures				
Kidney Disease				
Tuberculosis (TB)				
Arthritis				
Other				
Other				

Patient: _____ Date of Birth: ____/____/____

REVIEW OF SYSTEMS

	YES	NO		YES	NO		YES	NO
General			Diarrhea			**Psychiatric Problems?**		
Fever			Constipation			**Genito-Urinary**		
Weight loss			**Respiratory**			Any burning of urination		
Weight gain			Chronic Cough			Dark or discolored urine		
Fatigue			Emphysema			Difficulty starting/ending urine stream		
Craniofacial			Bronchitis			Poor control of bladder		
Abnormal shape or size of head?			Palpitations			Excessive thirst		
Cardiovascular			Asthma			**Endocrine**		
Shortness of breath			**Muscular and Skeletal**			Cold intolerance		
Chest pain			Neck/Back Pain/Injuries			Loss of body hair		
Irregular heart beat			Spasticity			**Skin and Breast**		
Poor circulation			Loss of Motion			Discharge from nipples		
High blood pressure			Scoliosis			Dry skin		
Low blood pressure			**Allergic / Immunologic**			Moles		
Hematologic Lymphatic			Body rash			**Other**		
Easy bruising			**Neurological**					
Nose bleeds			Headaches					
Gastrointestinal			Numbness					
Change in Appetite?			Weakness					
Increase / Decrease of Appetite			Dizziness					
Nausea / Vomiting			Seizures					

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of his / her staff responsible for any errors or omissions I may have made in the completion of this form.

INFORMATION GIVEN BY:

Name: _____

Relationship to child: _____ Date: _____

Parent or Guardian signature: _____

Relationship to child (if different from above): _____ Date: _____

Physician's signature: _____ Date: _____

UNIVERSITY OF OKLAHOMA
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14, 2003
LAST REVISED: October 1, 2018

This NOTICE describes your rights regarding your medical information and informs you of how it may be used and disclosed. It applies to the health information that is protected by the Health Insurance Portability and Accountability Act (HIPAA), used to make decisions about your care, and generated or maintained by the University of Oklahoma (OU). Please review it carefully.

By law, OU must protect the privacy of your health information, give you this Notice of OU's legal duties and privacy practices, and follow the current Notice. It will be followed by all employees, students, and volunteers of the health care components of OU, which include, but are not limited to the parts of these areas covered by HIPAA:

College of Allied Health
College of Dentistry
College of Medicine and OU Physicians
School of Community Medicine - Tulsa and OU Physicians – Tulsa
College of Nursing
College of Pharmacy
College of Public Health
Department of Athletics
OU Health Services - Goddard
OUHSC Student Counseling Services
University Counseling Center - Goddard
Certain administrative offices
Certain operations offices

1. Permitted Uses and Disclosures of Your Health Information
The following describe some of the ways that OU may use or disclose your health information without your authorization:

Treatment: To provide you with medical treatment/services and for treatment activities of other health care providers. *Examples:* Your health information may be used by doctors and students involved in your care. OU may use an electronic prescribing gateway with pharmacies.

Payment: For payment activities, such as to determine plan coverage or to bill/collect your account. *Example:* Your health information may be released to an insurance company to get pre-approval for services or to a collection agency if your account is not paid.

Operations: For uses necessary to run OU's healthcare businesses. *Example:* OU may use your health information to conduct internal audits to verify proper billing procedures.

Health Information Exchange: In a health information exchange (HIE), an organization in which providers exchange patient information to facilitate health care, avoid duplication of services (such as tests) and reduce the likelihood of medical errors. By participating in an HIE, OU may share your health information with other providers who participate in the HIE or participants of other HIEs. If you do not want your medical information in the HIE, you must request a restriction using the process outlined in paragraph 6 below or by contacting the HIE.

Education: To faculty, staff, current and prospective students, volunteer and visiting faculty, and trainees and observers as part of its educational mission. Education is part of OU's healthcare operations and treatment programs. *Example:* Your provider may discuss your case with students as part of a learning experience.

Business Associates: To other entities that provide a service to OU or on OU's behalf that requires the release of your health information, such as a billing service, but only if OU has received satisfactory assurance that the other entity will protect your health information.

Individuals Involved in Your Care or Payment for Your Care: To a friend, family member, or legal guardian who is involved in your care or who helps pay for your care.

Research: To researchers for Research if the authorization requirement has been waived or revised by a committee charged with making sure the disclosure will not pose a great risk to your privacy or that steps are being taken to protect your health information, to researchers to prepare for research under certain conditions, and to researchers who have signed an agreement promising to protect the information.

Organ and Tissue Donation: To donation banks or organizations that handle organ or tissue procurement or transplantation, if you are an organ or tissue donor.

Fundraising: OU may use (or release to an OU-related foundation) your name, DOB, address, department of service, outcome, physician, insurance status, and treatment dates for fundraising. If you do not want to be contacted for fundraising efforts, notify OU's Privacy Official at the phone number or address in Paragraph 6 below. OU will not sell your health information without your written permission.

Marketing: To send you information regarding treatment alternatives or other health-related products or services. You may opt out of receiving these communications by notifying OU's Privacy Official at the phone number or address in paragraph 6 below.

2. Required Uses and Disclosures of Health Information: The following describe some of the ways that OU may be allowed or required by law to use or disclose your health information without your authorization:

Required by Law/Law Enforcement: If required by federal, state, or local law, such as for workers' compensation, and if requested by law enforcement officials for certain purposes such as to locate a suspect or in response to a court order.

Public Health and Safety: To prevent a serious threat to the health and safety of you, others, or the public and for public health activities. *Example:* Oklahoma law requires OU to report birth defects and cases of communicable disease.

Food & Drug Administration (FDA) and Health Oversight Agencies: To the FDA and manufacturers to enable product recalls, repairs, or replacements; and to health oversight agencies for activities authorized by law, such as audits or investigations.

Lawsuits/Disputes: If you are involved in a lawsuit/dispute and have not waived the physician-patient privilege, OU may disclose your health information under a court/administrative order or subpoena.

OU Physicians

OU Children's Physicians

Patient Rights and Responsibilities

OU Physicians is dedicated to providing you with the best in healthcare. Along with technical expertise, we want to provide you with a positive patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care. These rights may be exercised by all patients who may legally self-consent for care or other person authorized to act on the patient's behalf, and they accept these patient responsibilities as well.

Patient Rights

You have the right to:

- Health care regardless of age, race, gender, religion, disability, national origin, or sexual orientation.
- Respect for personal dignity and privacy.
- Confidentiality of medical records: state and federal law forbids the release of your medical records without your written consent, except in specific situations where law requires OU Physicians to release information.
- Know the identity of the health care professional providing services.
- Expect diagnosis, prognosis, and method(s) of treatment to be explained clearly.
- Be informed about any risk of serious side effects.
- Participate in decisions involving your health care, including managing pain effectively.
- Know what alternatives exist for health care and treatment.
- Refuse medical care (except in specific situations as required by law).
- A second opinion.
- Know if treatment involves experimental or research protocols and the right to refuse participation.
- Express your concerns, if these rights have not been met.

Patient's Responsibilities

You have the responsibility to:

- Keep appointments as scheduled, or notify us in advance if you are unable to do so.
- Provide, to the best of your knowledge, accurate information relating to health history and current health status.
- Cooperate in the treatment plan recommended by those primarily responsible for your care.
- Consult your medical care provider if your health problem doesn't follow the expected course.
- Accept personal responsibility for refusing treatment.
- Abide by the health center and clinic regulations and policies.
- Respect the rights of OU Physicians personnel, other patients and visitors.
- Ask adequate questions to ensure understanding of your health problem and treatment.
- Parents and guardians have the responsibility to ensure that your child follows the course of treatment.
- Recognize that you make decisions daily that impact your personal health and treatment.
- Accept financial responsibility for services received, and provide information necessary to obtain insurance, Medicare, Medicaid, or other third-party payments.

Note: If you believe that your patient rights have not been met, contact the Clinic/Nurse Manager Stacey Snodgrass (405) 271-4912.

The University of Oklahoma
Department of Neurosurgery

1000 N Lincoln Blvd, Ste 4000
Oklahoma City, OK 73104
Ph 405-271-4912 / Fax 405-271-7834

Authorization to Release Protected Health Information **Verbally** to Others

Last Name: _____ First: _____ Middle: _____
Other Names Used: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ Alt. Phone: ( ) _____ Cell Phone: ( ) _____
If currently enrolled OU student, enrollment dates: _____ to _____

I _____ give my permission to: _____
Name of Physician, Provider, and/or Department/Clinic

to release **verbally** information regarding appointment dates/times and my protected health information checked below that it created or maintained from (date) _____ to (date) _____:

Verbally Release My Information to:			**Verbally** Release My Information to:		
Recipient Name:			Recipient Name:		
Relationship to Patient:			Relationship to Patient:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Fax:	Phone:		Fax:	Phone:	
Exceptions:			Exceptions:		

- Purpose of Request: ☐ referral ☐ legal ☐ transfer ☐ other: _____
- This authorization to release Protected Health Information **verbally** applies to discussions about information from my:

☐ Entire Health Record*
Excludes Billing Records/Notes and Psychotherapy Notes

☐ Entire Health Record plus Billing Records/Notes*
Excludes Psychotherapy Notes*

☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate copy of this form must be completed to obtain any other types of records.)

OR only these portions of my record:

☐ X-ray Reports/Films
☐ Immunization Records
☐ Discharge Summaries
☐ Medications
☐ Pathology/Lab Reports
☐ Billing Records
☐ Other: _____

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the clinic named in the upper left-hand corner or the University Privacy Official at University of Oklahoma Health Sciences Center, P.O. Box 26901, Oklahoma City, OK 73129. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be _____ months from the date of signature (12 months, if none entered).
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, OU may not condition the provision of treatment or payment for my care on my signing this Authorization.
- For non-students, information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Part 99 (FERPA).
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.**
- *The information authorized for verbal release may include information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.
- The information authorized for release may include substance use disorder records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. As a result, by signing below, I specifically authorize any such records included in my health information to be released. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.

_____ **Signature of Patient, Parent, or Authorized Legal Representative****
_____ **Relationship to Patient**
_____ **Date**

****May be requested to show proof of representative status**

File in Patient Chart

HIPAA Document
Retain for a minimum of 6 years