

**Blood & Marrow Transplant Group of Georgia
Patient Demographic Form**

*****Please complete entire form---Do not leave any blanks*****

Physician Information

Referring MD Name: _____ Primary Care Name: _____

Referring MD Number: _____ Primary Care Number: _____

Caregiver Information

1. Name: _____ Relation: _____

Home Phone Number: _____ Cell Phone Number: _____

2. Name: _____ Relation: _____

Home Phone Number: _____ Cell Phone Number: _____

Pharmacy Information

Name: _____ Phone: _____

Primary Insurance Information

Insurance: _____ Insurance Phone #: _____

Subscriber: (please circle) **Self Spouse Child** Name if different than patient: _____ DOB: _____

Employer Name & Number (if different than patient): _____

I.D. #: _____ Group#: _____

Secondary Insurance Information

Subscriber: _____ Relationship to Patient _____ DOB _____

Employer Name & Number (if different than patient): _____

Insurance: _____ Insurance Phone #: _____

I.D. #: _____ Group#: _____

Patient Signature: _____ **Date:** _____

Required Form Completion Checked by (staff member only): _____ Date: _____

**BLOOD & MARROW TRANSPLANT GROUP
OF GEORGIA
5670 PEACHTREE-DUNWOODY ROAD, N.E. • SUITE 1000
ATLANTA, GEORGIA 30342**

PHONE: (404) 255-1930 • FAX: (404) 459-8510

Medical Records Release Form/Request Form

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Georgia law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

I hereby authorize this medical Practice, Blood and Marrow Transplant Group of Georgia to release health information of patient named below:

Patient Name: _____ Date of Birth: _____

Soc. Sec. #: _____

(Other names, Maiden name): _____

Dates of Service to Release: _____ or _____ Entire Medical Record

Reason for Release: _____
(Reason for release must be noted on this form)

Please Print: Send medical records to: (REFERRING PHYSICIAN and/or any other Providers)

Name: _____

Address: _____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusion (Please initial): Drug/Alcohol _____, Mental Health/Psychiatric _____,

Sexually Transmitted Disease _____, HIV/AIDS _____, Other _____, description of other exclusions:

I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPPA, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by HIPPA. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that, if records are requested for any other purpose other than continuation of care, claim determination or for the completion of an initial disability application that fees may apply.

Effective July 1, 2006, The Georgia Office of Planning and Budget (OPB) pursuant to O.C.G.A. § 31-33-3, calculates an annual inflation adjustment for the costs related to medical record retrieval, certification and copying. The fee scale determined by BMTGA is as follows,

Search, Retrieval, and Other Direct Administrative Costs	Up to	\$24.86
Certification Fee	Up to per record	\$9.32
Copying Costs for Records in Paper Form	Per page for pages 1-20	\$0.93
	Per page for pages 21 - 100	\$0.80
	Per page for pages over 100	\$0.63

Refusal to Sign Authorization: I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective this date: _____ thru _____
(dates must be specified)

Signature: _____ **Print Name:** _____

Date: _____

I am the ___ Patient ___ Guardian ___ Conservator ___ Patient's Representative
(If this form was completed by someone other than the patient, please print full name.)

Name: _____

I understand that I have the right to receive a copy of this authorization.

Blood & Marrow Transplant Group of Georgia

**PATIENT AUTHORIZATION
TO RELEASE PROTECTED HEALTH INFORMATION TO
THIRD PARTIES**
Benefit release **for claims/eligibility**

Patient's Name Birth Date

Patient's ID#, SSN, or Chart # (Circle One)

Street Address City State Zip

I hereby authorize BMTGA to (check all that apply):
 Release to: verbally only in written form only both verbally and in writing
 Obtain from the parties I have indicated below.

**Description of individually identifiable health information (check appropriate type(s) of information)
to be released/exchanged/obtained. Note:** Clinical records used to make benefit determinations may include HIV/AIDS
and/or Substance Abuse information.

- All pertinent documentation BMTGA deems appropriate for the purpose(s) checked below
- Treatment Plan(s)
- Office Notes Only
- Diagnostic Reports Only
- Claims
- All records relating to a Disability claim(s)

The purpose of this release is: To allow the clinically appropriate management and coordination of the Patient's health and or coverage under the Patient's health benefit plan (Care Management and Coordination).

- Eligibility/Benefits
- Benefit Management/ Claims Administration/ Payment
- Administration of a Worker's Compensation claim
- Administration of a Disability claim
- Subpoena or other legal process
- Other (describe):

Blood & Marrow Transplant Group of Georgia

THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:

On ___/___/___ (MM/DD/YY), or upon termination of policy coverage, or 60 days after the termination of treatment, whichever is earlier.

OR

Once the following event occurs:

(Form must be completed before signing)

Signature of Patient/Legal Guardian or Patient's Representative Date

Signature of Minor Patient Date

Patient's Relationship to the Patient Print Name of Representative

The patient or the person signing this form has the right to receive a copy of this consent form. A copy of this form has been requested and received:

___ Yes ___ No Initials: _____ (patient)

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance abuse, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying BMTGA in writing, but if I do, it will not have any effect on any actions BMTGA took before it received the revocation.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION, with the understanding that this may delay patient care. Signing this form gives BMTGA staff and Northside Hospital Coordinators authorization to obtain or release medically necessary information that is pertinent to your immediate care. Refusal to sign this form may result in the delay of patient care due to insufficient documentation or vital medical information.

(If you refuse to sign this document please initial and date) Initials: _____ Date: _____

The Blood & Marrow
Transplant Group
O F G E O R G I A

5670 Peachtree Dunwoody Rd., Suite 1000, Atlanta, Georgia 30342

In an effort to continuously improve the operations of the Practice, the Clinic has implemented a system to maintain communication throughout the day between all Practice Clinicians and Caregivers. As part of this system, it is necessary to display your name and location in the Clinic during your visit. However, the Clinic wishes to meet your expectations of maintaining your privacy. Please complete the following consent form allowing the Clinic to display your name or request that your name not be displayed.

This consent will be kept on file as long as you are a patient with the Clinic. If at anytime you wish your decision to display your name or not to display your name to be changed, a new consent form can be completed.

During each of my Clinic visits, I understand that Blood & Marrow Transplant of Georgia wants to display my name ("patient") within the clinic setting, as part of an administrative communication system the Clinic utilizes.

I understand the Clinic wishes to meet my expectation of privacy. My wishes are as follows: *(initial your choice)*.

_____ I AGREE to allow the Clinic to display name in the Clinic setting as part of the administrative communication system the Clinic utilizes.

_____ I DO NOT want my name to be displayed in the Clinic setting as part of the administrative communication system the Clinic utilizes.

Date

Patient

Date

Staff Member - Witness

The Blood and Marrow Transplant Program at Northside Hospital
Atlanta, GA 30342

Infectious Disease Testing Consent
ACKNOWLEDGEMENT OF COUNSELING & CONSENT

Patient Name _____ MRN _____

Patient Sex _____ Race _____ Date of Birth _____

County of Residence _____ Zip Code _____

I give my permission for the collection of blood specimens from me (as in other blood tests) to detect whether I have antibodies in my blood to the Human T-Cell Virus Lymphotropic (HTLV) and/or Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS). A healthcare provider has counseled me regarding the HIV / HTLV antibody test and all my questions regarding the test have been answered. I understand that my blood may also be tested under an investigational research protocol. These tests are explained in attachments to this consent if indicated. I understand that I may be tested periodically under the discretion of my physician for HIV/HTLV and other infectious disease tests. I understand that I may rescind this consent at any time in writing. I understand that Blood & Marrow Transplant Group of Georgia will not release these test results or disclose the fact that I have been tested without my consent unless required or authorized by law. I understand that the results of my blood test will be reported to my doctor who will explain them to me.

I have been given an opportunity to refuse this test and I freely consent to have my blood collected and tested for the HIV / HTLV antibody, and if applicable, other infectious disease testing under an investigational protocol as described above.

If I am consenting on behalf of another, I confirm that I am the patient's parent, legal guardian, or next of kin and that the patient is unable to sign because:

Person Consenting to Test _____

Relationship to Patient if not Parent _____

Date _____

Witness _____

Effective Date of this Notice: April 1, 2003

BLOOD AND MARROW TRANSPLANT GROUP OF GEORGIA
ATLANTA BLOOD SERVICES
ATLANTA, GA 30342

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH
INFORMATION ABOUT YOU (AS A PATIENT OF THIS
PRACTICE) MAY BE USED AND DISCLOSED, AND HOW
YOU CAN GET ACCESS TO YOUR INDIVIDUALLY
IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE
CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

PRIVACY OFFICER

Blood and Marrow Transplant Group of Georgia
5670 Peachtree Dunwoody Road, Suite 1000
Atlanta, Georgia 30342
(404) 255-1930

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment-** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice -- including, but not limited to, our doctors and nurses -- may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment-** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations-** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointments-** Our practice may use and disclose your PHI to contact you and remind you of an appointment. In addition, we will also call you by name in our waiting room when it is time for you to be taken back for your scheduled appointment.
5. **Treatment Options-** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services-** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends-** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required By Law-** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks-** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
 - maintaining vital records, such as births and deaths
 - reporting child abuse or neglect
 - preventing or controlling disease, injury or disability
 - notifying a person regarding potential exposure to a communicable disease
 - notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - reporting reactions to drugs or problems with products or devices
 - notifying individuals if a product or device they may be using has been recalled
 - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
 - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. **Health Oversight Activities-** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement-** We may release PHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death we believe has resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, court order, subpoena or similar legal process
 - To identify/locate a suspect, material witness, fugitive or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Deceased Patients-** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research- Our practice may use and disclose your IIHI for research purposes in aggregate form for certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when:

- Our use or disclosure was approved by an Institutional Review Board or a Privacy Board
- We obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or
- The IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use of disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

Any published research study results will be in aggregate form. Your personal identifying information will NOT be published. Your records may be reviewed by an approved study monitor(s), clinical research employee(s) or BMT physician(s) to obtain clinical information.

7. **Serious Threats to Health or Safety-** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
8. **Military-** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
9. **National Security-** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. **Inmates-** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
11. **Workers' Compensation-** Our practice may release your IIHI for workers' compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications-** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342, (404) 255-1930 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions-** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930. Your request must describe in a clear and concise fashion:
 - (a) the information you wish restricted;
 - (b) whether you are requesting to limit our practice's use, disclosure or both; and
 - (c) to whom you want the limits to apply.
3. **Inspection and Copies-** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930 in order to inspect and/or obtain copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment-** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures-** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor is sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a twelve (12)-month period is free of charge, but our practice may charge you for additional lists within the same twelve (12)-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice-** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930.
7. **Right to File a Complaint-** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures-** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

PRIVACY OFFICER
Blood & Marrow Transplant Group of Georgia
5670 Peachtree Dunwoody Road, Suite 1000
Atlanta, Georgia 30342
(404) 255-1930

**BLOOD AND MARROW TRANSPLANT GROUP OF GEORGIA
ATLANTA BLOOD SERVICES
ATLANTA, GA 30342**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH
INFORMATION ABOUT YOU (AS A PATIENT OF THIS
PRACTICE) MAY BE USED AND DISCLOSED, AND HOW
YOU CAN GET ACCESS TO YOUR INDIVIDUALLY
IDENTIFIABLE HEALTH INFORMATION**

I hereby acknowledge that I have received and reviewed the Notice of Privacy Practices of **The Blood & Marrow Transplant Group of Georgia**. I have also been notified that a revised Notice of Privacy Practices may be obtained by forwarding a written request to **The Blood & Marrow Transplant Group of Georgia** Privacy Officer at 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342.

Patient Name (Printed)

Patient Signature

Date Acknowledged

**Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342**

PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ DATE: _____

SSN: _____ Ht: _____ Wt: _____

HOW WOULD YOU RATE YOUR GENERAL HEALTH: Excellent Good Fair Poor

PERSONAL/PAST MEDICAL HISTORY:

History of the following:	Yes	No	Comments
Asthma			
Pneumonia			
Tuberculosis			
Diabetes			
Heart Disease			
Hypertension			
Kidney Disease			
Liver Disease			
Thyroid Disease			
Arthritis			
Skin Disease			
Nervous Disorder			
Strokes			
Seizures			
CRS/Neurological Toxicity			
Venereal Disease			
Exposure to Hazardous Chemicals			

Additional Personal/Past Medical History:	Yes	No	Diagnosis Date	Comments
History of Herpes Zoster (Shingles)			/ /	
History of DVTs or Blood Clots			/ /	
Pneumothorax				
Myocardial Infarction			/ /	
CABG			/ /	
Stent placement			/ /	
Cardiomyopathy with EF <40%			/ /	
Valve replacement or repair			/ /	
Multiple Sclerosis				
Myasthenia Gravis				
Muscular Dystrophy				
Paraplegia/Quadriplegia				
History of major organ transplant or awaiting transplant			/ /	
Home Oxygen Use			/ /	
Sleep Apnea with or without CPAP			/ /	
History of Difficult Intubations or problems with anesthesia			/ /	

**Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342**

Have you ever tested positive for Hepatitis B, Hepatitis C, HIV or HTLV? Yes No

Do you or a close relative (brother, sister, mother, father, aunt, uncle, grandparent) have an inherited condition (such as sickle cell disease or trait, thalassemia, SC disease, genetic disorder, cystic fibrosis, etc.)? No Yes—Complete the following information:

Inherited Condition	Treatment	Relationship to You

Do you have a hematological disease (for example, hemophilia) or immunological disease (lupus, crohn's disease, rheumatoid arthritis, etc.)? No Yes—Complete the following information:

Disease	Year of Diagnosis	Treatment

Have you ever been treated for a malignant disease (Cancer)? No Yes—Specify below:

Type of Cancer	Diagnosis Date	Treatment Dates (include any prior transplants)

During previous hospitalizations, have you ever been placed on "CONTACT PRECAUTIONS" or "ISOLATION"? No Yes—Specify the reason(s) why below:

VRE MRSA Don't Know Other Reason: _____

List Any Other Illnesses, Injuries, and/or Surgeries:

Name of Illness, Injury, and/or Surgery	Year	Complications?

Dental Assessment:

When was your last dental exam? _____ Condition of Oral Cavity: _____

Please complete the following:

Childhood Illnesses	Yes	No	Year
Measles			
Mumps			
Chicken pox			
Polio			
Rheumatic Fever			
Other:			

Immunizations	Yes	No	Year
Small Pox			
Tetanus			
Polio			
Hepatitis			
MMR			

Transfusion History:

Have you ever received a Red Blood Cell (RBC) transfusion? No Yes—Specify below:

Did you experience a transfusion reaction? Yes No Require pre-medications? Yes No

Have you ever received a platelet transfusion? No Yes—Specify below:

Did you experience a transfusion reaction? Yes No Require pre-medications? Yes No

**Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342**

Allergy History: List all drugs, foods, tapes, latex, or substances (including albumin), to which you are allergic and specify the type of reaction you experience (e.g. itching, rash, wheezing, swelling, etc.)

Allergy	Reaction

FAMILY HISTORY:

History of the following:	Yes*	No	*If Yes, Relative(s)	Comments
Asthma				
Pneumonia				
Tuberculosis				
Diabetes				
Heart Disease				
Hypertension				
Kidney Disease				
Liver Disease				
Thyroid Disease				
Arthritis				
Skin Disease				
Nervous Disorder				
Strokes				
Seizures				
Venereal Disease				

FAMILY CURRENT STATUS:

Family Member	Age	State of Health
Father		
Mother		
Siblings: (include names)		
Children: (include names)		

Number of people living in your household: _____

Number of people under the age of 18 currently living in your household: _____

**Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342**

Social History:

Where were you born? (City, State or Country): _____

What is your ethnicity? Hispanic or Latino Not Hispanic or Latino

What is your Race? Check all that apply:

White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian / Other Pacific Islander	Decline
<input type="checkbox"/> Eastern European	<input type="checkbox"/> African	<input type="checkbox"/> Alaskan Native or Aleut	<input type="checkbox"/> South Asian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> I decline to provide race
<input type="checkbox"/> Mediterranean	<input type="checkbox"/> African American	<input type="checkbox"/> North American Indian	<input type="checkbox"/> Filipino (Pilipino)	<input type="checkbox"/> Hawaiian	
<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> American Indian, South or Central America	<input type="checkbox"/> Japanese	<input type="checkbox"/> Samoan	
<input type="checkbox"/> North Coast of Africa	<input type="checkbox"/> Black South or Central American	<input type="checkbox"/> Caribbean Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Pacific Islander	
<input type="checkbox"/> North American	<input type="checkbox"/> Other Black		<input type="checkbox"/> Chinese		
<input type="checkbox"/> Northern European			<input type="checkbox"/> Vietnamese		
<input type="checkbox"/> Western European			<input type="checkbox"/> Other Southeast Asian		
<input type="checkbox"/> White Caribbean					
<input type="checkbox"/> White South or Central American					
<input type="checkbox"/> Other White					

Marital status: Single (never married) Married/living with partner Separated Divorced Widowed

What is the highest educational grade or degree you've completed? _____

Are you currently in school or were you enrolled in school prior to your illness? Yes No

What is your Current / Most Recent Occupation? _____

**If not currently employed, list your last job; include any military service (if applicable)*

What is your current (or most recent) work status (within the last year)?

- Full Time Part time (by choice, not due to illness) Part Time (due to illness)
 Medical Disability Unemployed (not due to illness) Retired

Hobbies: _____

Travel History*: (Outside of the USA): _____

**Please list places and dates of travel*

Combined Household gross annual income*:

**Include earnings by all family members living in the household, before taxes*

- Less than \$20,000 \$20,000-\$39,999 \$40,000-\$59,999 \$60,000-\$79,999
 \$80,000-\$99,999 \$100,000 and over Decline to answer question

**Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342**

REVIEW OF SYSTEMS:

General:	Yes	No	Date of Onset (if unknown, leave blank)	Comments
Weakness			/ /	
Tiredness			/ /	
Pain			/ /	
Appetite changes			/ /	
Weight change			/ /	
Chills			/ /	
Fevers			/ /	
Night Sweats			/ /	
HEENT:				
Visual changes			/ /	
Hearing changes			/ /	
Nosebleeds			/ /	
Sinus problems			/ /	
Hoarseness			/ /	
Neck pain			/ /	
Dental problems			/ /	
Bleeding gums			/ /	
Respiratory:				
Cough			/ /	
Cough up blood			/ /	
Wheezing			/ /	
Shortness of breath at rest			/ /	
Shortness of breath with activity			/ /	
Cardiovascular:				
Chest pain			/ /	
Shortness of breath when lying flat			/ /	
Palpitations (irregular heart beat)			/ /	
Heart murmur			/ /	
Leg swelling			/ /	
Leg pain			/ /	
Blue/purple discoloration hands or feet			/ /	
Breasts:				
Monthly self-breast exam			/ /	
Lumps			/ /	
Pain			/ /	
Nipple discharge			/ /	
Gastrointestinal:				
Nausea			/ /	
Vomiting			/ /	
Diarrhea			/ /	
Constipation			/ /	
Change in bowel pattern			/ /	
Heart burn			/ /	
Abdominal pain			/ /	
Bright red blood in stools			/ /	
Black stools			/ /	
Hemorrhoids			/ /	
Urinary:				
Urinary tract infections			/ /	
Pain/burning on urination			/ /	
Frequent urination			/ /	
Difficulty starting/stopping stream			/ /	
Kidney stones			/ /	

**Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342**

REVIEW OF SYSTEMS—cont'd:

	Yes	No	Date of Onset (If unknown, leave blank)	Comments
Genito-reproductive: Male				
Discharge from penis			/ /	
Testicular pain			/ /	
Lumps in testicles or scrotum			/ /	
Decrease in testicular size			/ /	
Decreased sexual desire			/ /	
Decreased ability to achieve erection			/ /	
Genito-reproductive: Female				
Age of onset of periods:			/ /	
Age of menopause:			/ /	
Bleeding between periods			/ /	
Last normal period			/ /	
Do you have vaginal discharge			/ /	
Does intercourse cause pain			/ /	
Do you have decreased sexual desire			/ /	
Do you have hot flashes			/ /	
Are you taking female hormones			/ /	
Last pap smear			/ /	
Pregnancies, number:			N/A	
Number of live births:			N/A	
Musculoskeletal:				
Painful/stiff joints			/ /	
Swollen joints			/ /	
Muscle pain			/ /	
Back pain			/ /	
Endocrine:				
Heat/cold intolerance			/ /	
Tremulousness of hands			/ /	
Changes of body hair			/ /	
Increased thirst			/ /	
Increased urination			/ /	
Neurologic/Psychiatric:				
Depression			/ /	
Difficulty with sleep			/ /	
Memory changes			/ /	
Headaches			/ /	
Blackouts/Dizziness			/ /	
Weakness of limbs			/ /	
Numbness/tingling of limbs			/ /	
Loss of coordination/balance			/ /	
Skin:				
Dryness			/ /	
Rash/itching			/ /	
Changes in skin color			/ /	
Poor healing sores			/ /	
Easy bruising			/ /	
Nail changes			/ /	
Hair changes			/ /	

Yes, I confirm all information I have provided is true to the best of my knowledge.

Patient Signature: _____

Date: _____

**Blood and Marrow Transplant Program
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**DO NOT COMPLETE THIS SECTION
To be completed by Advanced Practice Provider / BMT Physician**

Circle ANY definition that applies to Recipient/Donor and document date of onset

Co-Existing DX	Definition	Date of onset:
Arrhythmia	Atrial fibrillation or flutter, sick sinus syndrome or ventricular arrhythmias	
Cardiac	Coronary Artery Disease, congestive heart failure, myocardial infarction, or EF <50%; HTN	
CNS	Transient ischemic attack, cerebrovascular accident, paralysis, meningitis/encephalitis, seizure disorder, stroke or CVA	
Chromosome	Downs Syndrome, Fanconi anemia	
Endocrine	Diabetes, (requiring treatment with insulin or oral hypoglycemics but not diet alone) Adrenal insufficiency, osteoporosis, thyroid disease	
Heart Valve Disease	Except mitral valve prolapse	
Hematologic	DVT, PE	
Hemorrhage; Significant	GI/GU/CNS	
Hepatic, mild	Chronic hepatitis; bilirubin > ULN to 1.5 x ULN; AST/ALT > ULN to 2.5 x ULN	
Hepatic, moderate/severe	Liver cirrhosis; bilirubin >1.5 x ULN, or AST/ALT >2.5 x ULN	
Infection	Requiring continuation of antimicrobial treatment	
Gastrointestinal	Inflammatory Bowel Disease; Crohn's disease, ulcerative colitis, PUD, GERD	
Obesity	Patients with a body mass index > 35 kg/m ²	
Psychiatric disturbance	Depression or anxiety requiring psychiatric consult or treatment	
Pulmonary, moderate	DLCO and/or FEV1 66-80% or dyspnea on slight activity; asthma, restrictive lung disease	
Pulmonary, severe	DLCO and/or FEV1, < 65% or dyspnea at rest or required oxygen; COPD	
Renal, moderate/severe	Serum creatinine > 2 mg/dL or > 177 umol/L, on dialysis, or prior renal transplantation	
Auto Immune	SLE, RA, polymyositis, mixed CID, or polymyalgia/rheumatica, MS, psoriasis	
Solid Tumor, prior	Treated at any time point in the patients' past history, excluding non-melanoma skin cancer	