SKAGIT VALLEY HOSPITAL
REGIONAL CANCER CARE CENTER
1415 EAST KINCAID STREET
MOUNT VERNON, WA 98274

NEW PATIENT RADIATION CONSULT FORM

Name:_____ Date:_____
Referring Dr:_____ Age:_____ DOB:_____
Primary Dr: _____ Sex:_____
Other Dr (s): _____

MEDICAL HISTORY: (Circle all that apply)

MI/Angina/CHF	Thyroid	Shingles
Hypertension	Diabetes	Hepatitis
CVA/TIA	TB	Skin Cancer
Seizures	COPD	Arthritis
Leukemia/Anemia	Pneumonia	Renal
Asthma		

History of any autoimmune or collagen vascular disease

Including: Lupus	Chrons	Systemic sclerosis
Multiple sclerosis	Scleroderma	Ulcerative colitis
Inflammatory bowel disease		

Other: _____

PREVIOUS SURGERIES OR SERIOUS INJURIES (Name of surgery and/or injury and estimated date)

_____
_____
_____
_____
_____

PREVIOUS RADIATION (BODY AREA RADIATED, YEAR, FACILITY)

_____

CHEMOTHERAPY (PAST AND CURRENT - WHAT, WHEN, WHERE)

_____
_____

DATE OF LAST DOSE OF CHEMO: _____

MEDICATIONS:

DRUG	DOSAGE	INSTRUCTIONS

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Medications continued:

_____

_____

_____

_____

_____

_____

ALLERGIES: Shellfish Contrast Latex

MEDICATION ALLERGIES / REACTIONS: _____

_____

FAMILY HISTORY OF CANCER (TYPE) :

IMMEDIATE FAMILY		**EXTENDED FAMILY**	
		MATERNAL	PATERNAL
Father _____	Aunt _____	_____	
Mother _____	Uncle _____	_____	
Sister(s) _____	Grandmother _____	_____	
_____			
_____	Grandfather _____	_____	
Brother(s) _____	Cousin(s) _____	_____	
_____	_____	_____	
_____	_____	_____	
Children _____			
_____			
_____			

HABITS: **AMT/DAY** **HOW LONG** **QUIT? WHEN?**

Cigarettes _____

Pipes/Cigars _____

Other _____

Beer/wine/other _____

SOCIAL HISTORY:

Marital Status _____ Occupation _____

Working Status **(CIRCLE)** FULL TIME PART TIME RETIRED

Living Situation _____

EXPOSURES: (CIRCLE ALL THAT APPLY)

Chemical Radiation

Other _____

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HEENT:

Dizziness Sinus Problems Nose Bleeds
Visual Changes Difficulty swallowing Hoarseness
Other:_____

Cardiovascular:

Chest Pain Swelling Blood Clots
Varicose Veins Vascular Access Device (i.e. port, IV)
Other: _____

Respiratory:

Shortness of Breath Home Oxygen Tracheotomy
Cough Color of Sputum_____
Other: _____

Gastrointestinal:

Nausea Vomiting Vomiting up Blood Constipation
Diarrhea Blood in Stool Last BM_____ Ostomy
Other: _____

Genitourinary:

Burning Urgency Frequency - How often _____
Nocturia X _____ Hesitancy Incontinence
Urinary tract infections Blood in Urine Ostomy
Other: _____

Reproductive: FEMALE:

Menarche (age) _____ Menopause (age) _____
Number of live births _____ Number of Pregnancies _____
Menstrual Cycle _____ Date of last Cycle_____
Bleeding _____ Spotting _____ Discharge _____ Last Pap _____
BCP/Hormones _____
Other: _____

Male:

History of: Prostatitis BPH Enlarged Breast
Recent PSA _____
Other: _____

Integumentary:

Sun Sensitivity Rash Dry Skin
Comments: _____

Musculoskeletal:

Muscle Weakness Back Pain Joint Pain
Other: _____

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Hematologic/Lymphatic:

Heat Intolerance Cold Intolerance Glandular Swelling
Lymphedema Bruising Tendancy Bleeding Tendancy
Other: _____

Pain:

Currently Painful? Location _____
Affects Sleep New Pain? Persist greater than 5 days?
Efficacy of Meds: _____
Other: _____

Advance Directives:

Living Will Durable Power of Atty Code Status
Other: _____

MISCELLANEOUS COMMENTS OR CONCERNS _____

_____
_____
_____
_____
_____
_____
_____
_____

VITAL SIGNS: (TO BE FILLED IN BY STAFF)

HT: _____ WT: _____ Normal WT: _____ T: _____
BP: _____ P: _____ R: _____ O_2 Sat: _____

RN SIGNATURE: _____ **DATE:** _____

MD SIGNATURE: _____ **DATE:** _____

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VERBAL RELEASE OF INFORMATION

Skagit Valley Hospital is allowed to give verbal medical information or updates about your condition to your Power of Attorney for Healthcare/Legal Representative as listed in your medical record.

If you wish others, such as relatives or friends, **who ask** about your condition, the right to be verbally informed about your condition when they ask, please list the names of those people on the lines below. Others might include your spouse, son or daughter, grandchild, niece, nephew, neighbor or friend.

I, _____, as a patient of Skagit Valley Hospital or legal representative of the patient, authorize the release of verbal medical information regarding my treatment and care and updates on my conditions to the following individuals.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

_____ _____
Patient/Legal Representative Date

This form will be updated at each admission or upon request by the patient/legal representative. This form is to be forwarded to the unit clerk and kept in the chart in the back of the facesheet.

VERBAL RELEASE OF INFORMATION

S3545