UCSF Helen Diller Family Comprehensive Cancer Center

Patient Name:

Date of Birth:

Cancer Treatment History

1. **Have you ever received treatment with radiation therapy in the past?**

☐ **YES** ☐ **NO** *skip next question*

2. **If YES, please provide the following information:**

Type of Cancer	Name of Facility/Hospital	Name of Radiation Oncologist	Phone Number *(if known)*

3. **Have you ever received treatment for cancer with chemo/hormonal therapy in the past?**

☐ **YES** ☐ **NO** *skip next question*

4. **If YES, please provide the following information:**

Type of Cancer	Name of Facility/Hospital	Name of Oncologist	Phone Number *(if known)*

National Comprehensive Cancer Network®

NCCN Distress Thermometer for Patients

Help for distress

Distress is an unpleasant emotional state that may affect how you feel, think, and act. It can include feelings of unease, sadness, worry, anger, helplessness, guilt, and so forth. Everyone with cancer has some distress at some point of time. It is normal to feel sad, fearful, and helpless.

Feeling distressed may be a minor problem or it may be more serious. You may be so distressed that you can't do the things you used to do. Serious or not, it is important that your treatment team knows how you feel.

The Distress Thermometer is a tool that you can use to talk to your doctors about your distress. It has a scale on which you circle your level of distress. It also asks about the parts of life in which you are having problems. The Distress Thermometer has been tested in many studies and found to work well. Please complete the Distress Thermometer and share it with your treatment team at your next visit.

The Distress Thermometer helps your treatment team know if you need supportive services. You may be referred to supportive services at your cancer center or in your community. Supportive services can include help from support groups, chaplains, social workers, counselors, and many other experts. Supportive services can also be found through the support services at right.

Support Services

National Cancer Institute's Cancer Information Service

Telephone
1-800-4-CANCER

Website
www.cancer.gov/aboutnci/cis/page1

Cancer Support Community

Telephone
1- 888-793-9355

Website
www.cancersupportcommunity.org/MainMenu/Cancer-Support

U.S. Health Resources and Services Administration

Website
www.findahealthcenter.hrsa.gov/Search_HCC.aspx

U.S. Substance Abuse and Mental Health Services Administration

Website
www.findtreatment.samhsa.gov

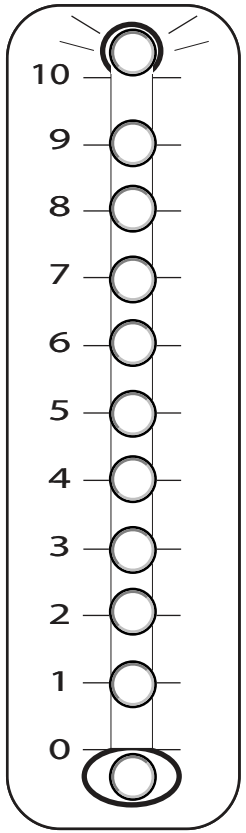
National Comprehensive Cancer Network®

NCCN Distress Thermometer for Patients

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress



No distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
○	○	Child care
○	○	Housing
○	○	Insurance/financial
○	○	Transportation
○	○	Work/school
○	○	Treatment decisions

YES	NO	Family Problems
○	○	Dealing with children
○	○	Dealing with partner
○	○	Ability to have children
○	○	Family health issues

YES	NO	Emotional Problems
○	○	Depression
○	○	Fears
○	○	Nervousness
○	○	Sadness
○	○	Worry
○	○	Loss of interest in usual activities

YES	NO	Spiritual/religious concerns
○	○	

YES	NO	Physical Problems
○	○	Appearance
○	○	Bathing/dressing
○	○	Breathing
○	○	Changes in urination
○	○	Constipation
○	○	Diarrhea
○	○	Eating
○	○	Fatigue
○	○	Feeling Swollen
○	○	Fevers
○	○	Getting around
○	○	Indigestion
○	○	Memory/concentration
○	○	Mouth sores
○	○	Nausea
○	○	Nose dry/congested
○	○	Pain
○	○	Sexual
○	○	Skin dry/itchy
○	○	Sleep
○	○	Substance abuse
○	○	Tingling in hands/feet

Other Problems: _____

_____

UCSF Medical Center

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

OUTPATIENT PAIN SCREENING RECORD

Have you experienced any pain within the past week? No ◯ Yes ◯

(If "No," stop here and give this to your provider. If "Yes," please answer the rest of the questions)

Where is your pain? _____

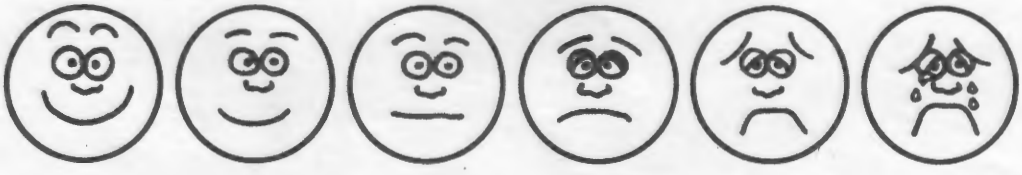
Circle a number from 0-10 that best describes how much pain you are having now.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Possible

For a child or non-English speaking adult, use Wong-Baker FACES Pain Rating Scale© or FLACC Pain Scale.

Ask the patient to circle the score that best describes how he/she feels:



0 — No Hurt | 1-2 — Hurts Little Bit | 3-4 — Hurts Little More | 5-6 — Hurts Even More | 7-8 — Hurts Whole Lot | 9-10 — Hurts Worst

FLACC PAIN SCALE

Categories	Scoring		
	0	1	2
FACE	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant quivering chin; clenched jaw.
LEGS	Normal position or relaxed.	Uneasy, restless, tense.	Kicking, or legs drawn up.
ACTIVITY	Lying quietly, normal position, moves easily.	Squirming, shifting back and forth, tense.	Arched, rigid or jerking.
CRY	No cry (awake or asleep).	Moans or whimpers; occasional complaint.	Crying steadily, screams or sobs - frequent complaints.
CONSOLABILITY	Content, relaxed.	Reassured by occasional touching, hugging, or being talked to - distractible.	Difficulty to console or comfort.

What does your pain feel like? Click Word to Select: sharp, dull, burning, aching, throbbing, tender, numb, stabbing, gnawing, shooting, exhausting, penetrating, miserable, unbearable, continuous, occasional

What makes the pain better? _____

What makes the pain worse? _____

Are you currently taking medication(s) or using some type of treatment for pain relief? No ◯ Yes ◯

If yes, list medication and/or treatment: _____

Patient or Caregiver Signature _____ Date _____

775-075 (Rev. 08/09) WorkflowOne ORIGINAL MEDICAL RECORD COPY YELLOW – PRACTICE COPY

UCSF Medical Center

UCSF Benioff Children's Hospital

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT OF RECEIPT

The UCSF Notice of Privacy Practice provides information about how we may use and disclose protected health information about you.

In addition to the copy we have provided you, copies of the current notice are available by accessing our website at http://www.ucsfhealth.org and may be obtained throughout UCSF Health System.

I acknowledge that I have received the Notice of Privacy Practice.

_____ _____ / _____ / _____

Signature of Patient or Patient's Representative Date

_____ Self (patient)

Print Name Relationship to Patient

_____

Name of Interpreter (if applicable)

If written acknowledgement is not obtained, please check reason:

☐ Notice of Privacy Practice Given - Patient Unable to Sign

☐ Notice of Privacy Practice Given - Patient Declined to Sign

☐ Other _____

_____ _____ / _____ / _____

Signature of UCSF Representative Date

_____ _____

Print Name Department

876-060 (Rev 09/13) WorkflowOne WHITE – MEDICAL RECORD YELLOW – PATIENT OR PATIENT'S REPRESENTATIVE

UCSF Medical Center

UCSF Benioff Children's Hospital

DATE:

PATIENT NAME:

BIRTHDATE:

ID VERIFICATION (TYPE):

ID VERIFIED BY:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize _____ (1)
(Name of person or facility which has information - example: UCSF/Mt. Zion)
to release health information to:
___UCSF Medical Center: Cancer Center_____
Name of person or facility to receive health information (full address)

_____

Street address:

_____

City, State, Zip Code

_____

The purpose of this release is for (check one or more):

- [X] Continuity of care or discharge planning
- [ ] Billing and payment of bill
- [ ] At the request of the patient/ patient representative
- [ ] Other (state reason)_____

_____

_____

Please specify the health information you authorize to be released: (2)

Type(s) of health information: _____

Date(s) of treatment: _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below: (3)

- [ ] Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- [ ] Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)
- [ ] Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- [ ] Release of genetic testing information (Health and Safety Code §124980(j)).

EXPIRATION OF AUTHORIZATION (4)

Unless otherwise revoked, this Authorization expires _____(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____

Print Name | Signature (Patient, Parent, Guardian)

_____ _____

Date Time | Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

Requested format: [ ] Paper [ ] CD

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

NOTICE
UCSF and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS
This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Health Information Management Services, UCSF Medical Center, 400 Parnassus Ave., Room A68, San Francisco, CA 94143-0308. The revocation will take effect when UCSF receives it, except to the extent UCSF or others have already relied on it.

You are entitled to receive a copy of this Authorization.

Made accessible
2/23