

UCSF Helen Diller Family
Comprehensive
Cancer Center

Dear New Patient,

This letter is to welcome you to the Melanoma Program at the UCSF Helen Diller Family Comprehensive Cancer Center. We hope your visit here will be as informative, reassuring and productive as possible.

The Melanoma Center is a full service practice located at several different clinics at the Mt Zion campus. Our providers consist of dermatologist, surgeons, and oncologists. Depending on the type of stage of the melanoma, you may be seen by any or all of these specialists (please refer to the attached flyer).

At your new patient visit, you will first meet with and be examined by one of the physicians or nurse practitioners who work closely with our melanoma specialists. Then you will meet with the specialist who will outline the recommendations for further treatment (if necessary) and discuss a program of follow-up visits.

Our goal is to comprehensively evaluate you and offer treatment options that are personalized. We offer both standard and approved treatments for melanoma, as well as new developing therapies that are part of our clinical trials program.

Your referring physician will be notified by telephone or fax of the results of our evaluation and a written report will be sent shortly thereafter.

In order for us to best serve you, it is helpful to have as much information about you as possible at the time of your visit. For this reason, please refer to the following check lists:

Required information for you to **send prior** to your appointment:

Surgical (i.e. operative) reports

Pathology reports and corresponding microscopic slides of all your biopsies

Radiology discs and reports (x-rays, CT scans, and/or MRI scans, PET scans)

Laboratory results (blood and urine tests)

Enlarged copy of front and back of your **insurance card(s)**

Referral or Authorization from your insurance company (for billing codes 99245 and 88321)

Pathology (microscopic) slides of all your biopsies

Microscopic slides of all biopsies are essential and should be mailed to:

Dermatopathology

Attn: May Crisologo

1701 Divisadero St, 3rd floor

San Francisco, CA 94115 (415) 353-7546

(All tissue samples will be reviewed. This examination is of great importance since the recommendations for treatment will depend to a large degree upon features noted in the pathologic interpretation. This examination will be done even though a previous pathology examination has been made. There will be a separate fee for this examination.)

Melanoma & Oncology Center
1600 Divisadero Street, 4th Fl.
San Francisco, CA 94115

Mailing Address:
UCSF Box 1706 San Francisco,
CA 94143

Tel: 415.353.9900
Fax: 415.885.3802
Alt Fax: 415.353.9931



A Comprehensive Cancer
Center Designated by the
National Cancer Institute

Required information for you to **hand carry** to your appointment:

- Completed **Health Questionnaire** form
- Completed **Referring Physician Contact Information** form
- List of your current **medications**
- Please notice:** Effective May 1, 2009 UCSF Medical Center requires patients to show a valid government issued picture ID at every visit.

Information for you to **read / review** prior to coming to your appointment:

- Letter describing fee services
- Information on your Radiology films and how to obtain them
- Information on Disability paperwork
- Information on Social Work Services
- Map, directions, and parking
http://www.ucsfhealth.org/adult/patient_guide/dir_mountzion.html
- Lodging guide http://cancer.ucsf.edu/crc/mtz_lodging.pdf

Patients with cancer are increasingly surviving their disease, although many are faced with significant challenges regarding quality of life. One important aspect of survival is being able to have a child in the future. The UCSF Center for Reproductive Health helps women and men whose lives have been affected by cancer to preserve their fertility. We work with a multidisciplinary team of specialists before, during, and after treatment to ensure that parenthood remains an option. For more information on this service please contact the (415) 353-9115 or visit them at <http://www.ucsfivf.org/>.

Our goal is to provide health care tailored to fit your needs. Our doctors, nurses and other staff look forward to collaborating with you to achieve this goal. We believe that the most important member of your health care team is you, so we welcome your questions, suggestions and other input.

Please arrive 30 minutes prior to your appointment. If you are unable to come to your appointment, please notify our office immediately.

I would like to hear from you if you experience challenges in our department. We are always striving to do our best, and your input is of great value. Please do not hesitate to contact me.

Yours truly,

Betty Lopez-Jurado,
Practice Manager

IMPORTANTE!!!

Estimado/a paciente, favor de llenar este cuestionario y regresarlo a nuestra oficina por lo menos 3 dias antes de su cita en nuestro departamento. Al tener esta informacion antes de su cita, nos ayudara a estar mejor preparados para su consulta. Gracias

Очень Важно!!!

Пожалуйста заполните этот документ как можно скорее и возвратите его к нам до вашего посещения! Наличие этой информации заранее поможет нам подготовиться к вашему визиту. Мы должны получить ваш заполненный анкетный опрос по крайней мере 3 дня до вашего запланированного визита. Если Вы не можете читать или писать на английском языке, пожалуйста попросите, чтобы Вам помог член семьи или друг если возможно.

通告

親愛的病患:

注意項目: 健康問卷

請將健康問卷盡早填寫。此健康問卷將幫助我們準備您將來的醫生預約;我們的目標是在您會見醫生三天之前收到這份健康問卷,煩請盡快遞交。如果您有任何讀寫英語的困難,敬請您的家人或朋友協助填寫。

IMPORTANT!!!

Please complete this document **as soon as possible** and return it to us **prior to your visit!!** Having this information in advance will help us prepare for your appointment! If you are unable to read or write in English, please ask a family member or friend to assist you if possible.

Please return by:

- Fax (preferred) 415-885-3802
- Mail (only if at least 2 wks before your appointment)
Please keep a copy and bring it with you to your appointment in case we have not received it in time!

Questionnaire Processing
UCSF Helen Diller Family Comprehensive Cancer Center
1600 Divisadero Street, 4th floor, Melanoma Oncology
San Francisco, CA 94115

- Bring completed form with you to your appointment.



UCSF Helen Diller Family
Comprehensive
Cancer Center

PATIENT HEALTH QUESTIONNAIRE

Complete on each page

Patient Name: _____

Date of Birth: _____

Thank you for choosing the UCSF Helen Diller Family Comprehensive Cancer Center. We are currently transitioning to a new electronic medical record called APeX. In order to update our records we are asking for your help in providing the following information, some of which you may have provided in another format. We apologize if this is duplicative. Your answers will become part of the UCSF medical record and will be confidential. *Please be sure to complete your name and date of birth on each page of this document.*

PHARMACY INFORMATION

Pharmacy Name: _____

Address: _____ City _____ State _____

Phone: (_____) _____ Fax (_____) _____

ALLERGIES

Have you ever had a reaction to any of the following:

(X)

Eggs	anaphylaxis/shock other (describe):	rash	itching	nausea/vomiting	short-of-breath
Latex	anaphylaxis/shock other (describe):	rash	itching	nausea/vomiting	short-of-breath
Iodine (including shellfish)	anaphylaxis/shock other (describe):	rash	itching	nausea/vomiting	short-of-breath
Bee stings	anaphylaxis/shock other (describe):	rash	itching	nausea/vomiting	short-of-breath
Intravenous contrast agent (used in CT scans)	anaphylaxis/shock other (describe):	rash	itching	nausea/vomiting	short-of-breath

Are you allergic to any medications? If so, list the medication and the reaction that you had:

MEDICATION	REACTION (circle all that apply)
Example: Aspirin	anaphylaxis/shock <u>rash</u> itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:



UCSF Helen Diller Family
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PATIENT HEALTH QUESTIONNAIRE

Complete on each page

Patient Name: _____

Date of Birth: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home () _____ Cell () _____ Work () _____

Fax: () _____ Email Address: _____

Is English your primary language? Yes No

If "No", what is your primary language? _____

How well do you speak English? (circle one) Very Well Well Not Well Not at all

In what language do you prefer to receive your healthcare? _____

What is your preferred method of being contacted by our office?

(rank your preferences: 1=first preference, 5=last preference)

home phone _____ cell phone _____ work phone _____ email _____ mail letter to home address _____

we will make every attempt to contact you using your preferred method, however you may receive communication from us by any of these methods

If you are not comfortable with any of the above methods of communication, do you have a preferred relative or friend we should contact instead or another suggestion?

Preferred contact person(s) and relationship to you: _____

Phone: Home () _____ Cell () _____ Work () _____

Other suggestions: _____

Who else can we speak to about your healthcare?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____



UCSF Helen Diller Family
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PATIENT HEALTH QUESTIONNAIRE

Complete on each page

Patient Name: _____

Date of Birth: _____

Please list all physicians who care for you and their **complete addresses** so that we can send them updates on the treatment you receive at the UCSF Comprehensive Cancer Center. This information is **REQUIRED**.

Referring MD:

Name: _____ Specialty or PCP _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____ (Fax) (____) _____

Primary Care Physician: Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____ (Fax) (____) _____

Surgeon: Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____ (Fax) (____) _____

Medical Oncologist: Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____ (Fax) (____) _____

Radiation Oncologist: Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____ (Fax) (____) _____

Cardiologist: Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____ (Fax) (____) _____

Other doctor(s) I would like reports sent to:

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____ (Fax) (____) _____



UCSF Helen Diller Family
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PATIENT HEALTH QUESTIONNAIRE

Complete on each page

Patient Name: _____

Date of Birth: _____

MEDICATIONS

Please list all medications you are **currently taking**.

Name of Medication	Dosage strength of medication (i.e. for each pill or patch, or the liquid concentration)	Amount of medication taken with each dose	Frequency	Start Date
<i>EXAMPLE acetaminophen –Tylenol morphine liquid-Roxanol</i>	<i>500 mg 20mg/mL</i>	<i>1 pill 0.5 mL</i>	<i>Every 4 hours Every 3 hours as needed</i>	<i>8/2011</i>



Complete on each page

Patient Name: _____

Date of Birth: _____

PAST MEDICAL HISTORY

Please complete the section below for any illnesses / conditions you have now or in the past.

	(X)		(X)
Arrhythmias & Coronary Artery Disease (CAD)		Hiatal hernia	
Anemia (low red blood cell count)		HIV/AIDS	
Angina (heart pain from poor blood flow)		Hypertension /High Blood Pressure	
Anxiety or panic attacks		Immune disorders	
Arthritis		Intestinal disease/problems	
Asbestos exposure		Liver disease	
Asthma/Bronchitis		Lung disease	
Atrial fibrillation (A fib or heart flutter)		Melanoma	
Autoimmune disease		Migraine headaches	
Bleeding disorders (hemophilia)		Morbid Obesity (BMI \geq 38)	
Blood disorder		Myocardial infarction (MI/Heart attack)	
Blood transfusion in the past		Nerve/muscle disease	
Cancer (list types) NEXT PAGE		Osteoporosis (loss of bone strength)	
Chest pain			
Chronic bronchitis		Pancreatitis (chronic)	
Chronic obstructive pulmonary disease (COPD)		Palpitations/Fast or irregular heart beats	
Cirrhosis (liver failure)		Peripheral vascular disease	
Clotting disorder		Psychiatric treatment (mental illness)	
Congestive Heart Failure (CHF)		Pulmonary embolism (blood clot in the lung)	
Deep Vein Thrombosis (DVT)		Renal disease/failure/insufficiency/ CRI	
Depression		Seizures/Epilepsy	
Diabetes Mellitus -IDDM (taking insulin)		Sinus disorder	
Diabetes Mellitus- NDDM(not taking insulin)		Skin disease	
Easy bruising		Stomach ulcers	
Emphysema		Stroke/Transient Ischemic attack/TIA/Mini-stroke	
Gastroesophageal reflux (heartburn) GERD/chronic heartburn, stomach reflux		Substance abuse	
GI bleed		Thyroid disease	
Glaucoma		Tuberculosis (TB)	
Heart murmur		Ulcers (open sores that don't heal)	
Heart valve problems		Other:	
Hepatitis chronic		Other	

Have you ever been hospitalized? If yes, list the date(s) and reasons.

Date

Reason



UCSF Helen Diller Family
Comprehensive
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PATIENT HEALTH QUESTIONNAIRE

Complete on each page

Patient Name: _____

Date of Birth: _____

NEW PATIENTS ONLY (PLEASE COMPLETE THIS SHADED SECTION)
YOUR CANCER HISTORY

Date of Diagnosis _____ Cancer Type _____

Treatment received: _____

Date of Diagnosis _____ Cancer Type _____

Treatment received: _____

PRIOR CHEMOTHERAPY

Drug regimen: _____

Approximate start date: _____ Date of last dose: _____ Number of Cycles _____

Drug regimen: _____

Approximate start date: _____ Date of last dose: _____ Number of Cycles _____

Drug regimen: _____

Approximate start date: _____ Date of last dose _____ Number of Cycles _____

RADIATION THERAPY

Area of body radiated: _____

Approximate start date: _____ Date completed: _____ Dose (if known): _____

PAST SURGICAL HISTORY

Please mark any operations you have had.

Name of Operation	Yes	Date/Type/Location/Other Comments
Appendix surgery		Location of hernia: What joint:
Brain surgery		
Breast surgery		
Caesarean section (C-section)		
Colon surgery		
Coronary artery bypass surgery (CABG)		
Gallbladder surgery		
Heart valve replacement (pacemaker)		
Hernia repair		
Hysterectomy (uterus removal)		
Joint replacement		
Liver surgery		
Ovary surgery		
Pancreas surgery		
Prostate surgery		
Spine surgery		
Tonsillectomy		
Tubal ligation		
Vasectomy		
OTHER		



Complete on each page

Patient Name: _____

Date of Birth: _____

FAMILY HISTORY

FAMILY HISTORY: Please take a moment to tell us about the history of cancer and other medical conditions in your family. Please list all family members living or deceased.

Relationship to you	Current Age of Relative	Type of Cancer	Other Medical Conditions	Age at Diagnosis	If Deceased, Age at Death
Mother					
Father					
Sister					
Sister					
Brother					
Brother					
Daughter					
Son					
Maternal Aunt					
Maternal Uncle					
Paternal Aunt					
Paternal Uncle					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Other					

HABITS

Do you drink alcohol? YES NO If yes, what is your average number of:

	glasses of wine per week
	cans of beer per week
	shots of liquor per week

Do you use drugs recreationally now? YES NO If yes, *circle* the drugs you use:

amphetamines	amyl nitrate	anabolic steroid	barbiturates	Benzodiazepines Such as Xanax, Ativan, Valium	"crack" cocaine
cocaine	codeine	fentanyl	GHB	heroin	hydrocodone
hydromorphone	ketamine	LSD	marijuana	MDMA ecstasy	methamphetamine
methaqualone	methylphenidate	morphine	nitrous oxide	opium	oxycontin
PCP	Psilocybin	solvent inhalants	IV drugs	other:	other:

Are you a (circle one): current smoker former smoker never smoker passive (2nd hand) smoker

Do you smoke CIGARETTES, CIGARS, OR PIPE TOBACCO? (Circle all that apply)

How many years have you smoked? _____

How many **packs of cigarettes per day** do you (or did you) smoke, on average? _____

If you are a former smoker, what date did you quit? _____

Do you chew tobacco (circle one) never currently how much _____ in the past when _____



Complete on each page

Patient Name: _____

Date of Birth: _____

SOCIAL HISTORY

If you exercise, how many minutes per week? _____ And what is your usual type(s) of exercise? _____

What is your usual walking pace? (circle one)

Easy (>30 min/mile) normal (21-30 min/mile) brisk (<=20 min/mile) unable to walk

Have you experienced any unplanned weight loss in the last three months? No Yes

If yes describe: _____

Have you had difficulty chewing or swallowing in the last 3 months? No Yes

If yes describe: _____

In the past 12 months, have you been hurt or felt threatened by someone close to you? No Yes

If yes describe: _____

In the past 12 months, have you experienced any distress? (this includes depression, feeling "down", anxiety) No Yes

If yes describe: _____

Have you ever been so sad or upset that you thought about hurting yourself or others? No Yes

If yes describe: _____

Do you have any special cultural or spiritual beliefs or desires? No Yes

If yes describe: _____

Have you fallen more than once in the past 1 month? No Yes

If yes describe: _____

Have you ever had any difficulty with reading, translation of materials, vision or physical problems that prevented you from understanding your treatment/care plan? No Yes

If yes describe: _____

How do you learn best (for example, reading, listening to an audio tape, looking at pictures, etc?)

Do you live alone? If not, who is at home with you? _____

What is your marital status? Single Married Partnered Divorced Widowed

If you have children, how many? _____ How many biological children? _____

What are your children's ages and gender? _____

Education level: Select one that best describes your education level

Some grade school Some high school High school graduate Some college or associate's degree

Vocational / Technical school beyond high school College Graduate or professional school

What is your current employment status? Employed full time (more than 37 hours)

On medical leave / Disabled Retired Employed part time (less than 37 hours) Other _____

Current Occupation: _____ Employer: _____ How long: _____



Complete on each page

Patient Name: _____

Date of Birth: _____

SECOND-HAND SMOKE EXPOSURE

1. Did your mother smoke cigarettes when she was pregnant with you? Yes No Unknown
2. While growing up until age 18, how many years did you live in the same household with someone else who smoked tobacco products? _____
3. Since age 18, how many years in total did you live in the same household with someone else who smoked tobacco products? _____
4. Thinking about all of the jobs you have held, for how many years of employment have you been exposed to another person's tobacco smoke inside your workplace? _____

PERFORMANCE STATUS

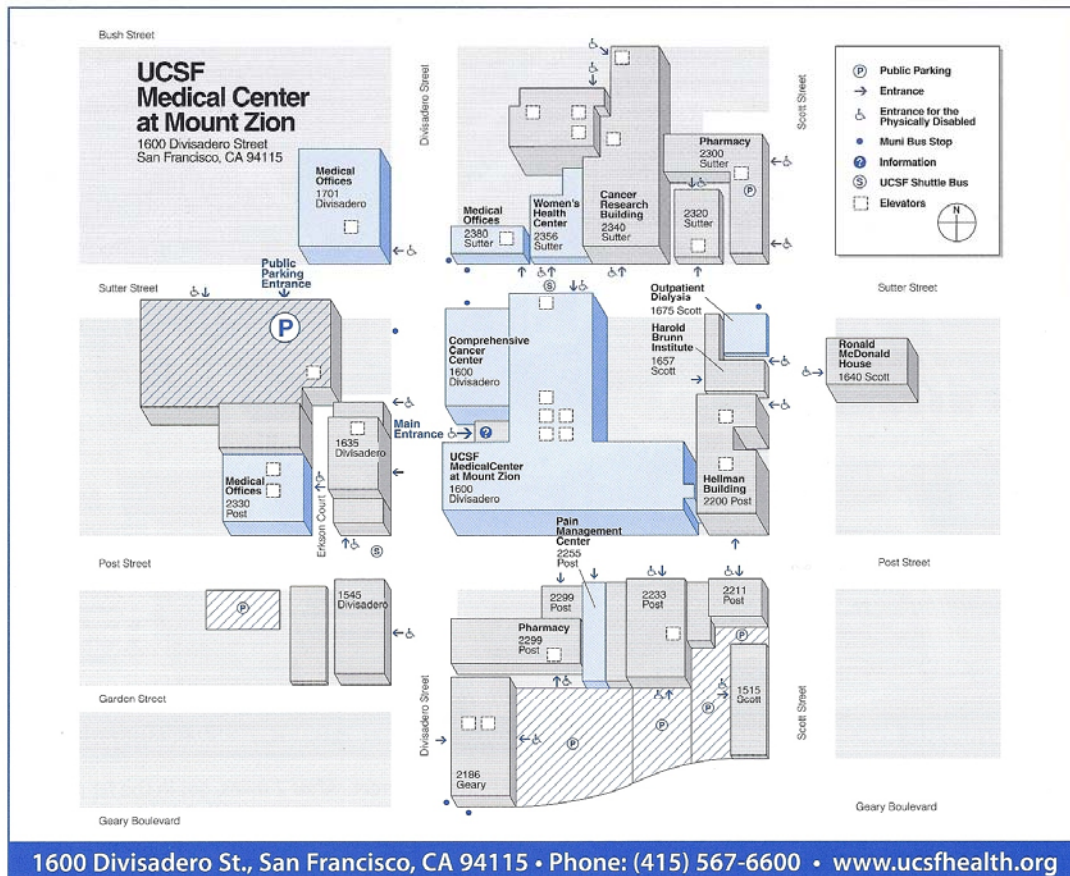
Please circle the number next to the statement that best describes your activity on a typical day:

- 0 I am fully active and able to carry on my day-to-day activity without restrictions.
- 1 I am restricted in physically strenuous activity but I can walk and carry out light work such as light house work and office work.
- 2 I am up and about for more than 50% of waking hours. I am capable of all self-care but unable to carry out any work activities.
- 3 I am capable of only limited self-care and I am confined to a bed or chair more than 50% of waking hours.
- 4 I am completely disabled. I cannot carry on any self-care and am totally confined to a bed or chair.

Maps to UCSF Locations

For detailed maps and directions from your location to **any** of our UCSF Medical Center campuses, please click on this link: <http://pathway.ucsfmedicalcenter.org>

UCSF Medical Center at Mount Zion



From Marin County (Highway 101): From the Golden Gate Bridge, take the "DOWNTOWN" exit to LOMBARD ST. Turn RIGHT on DIVISADERO ST. and continue to UCSF Medical Center at Mount Zion.

From the East Bay and Oakland Airport (I-80): After crossing the Bay Bridge, stay in the second lane from the right. EXIT to the right on "101 NORTH/GOLDEN GATE BRIDGE." Get in the left lane and EXIT on "OCTAVIA BLVD/FELL STREET." After 4 blocks, turn LEFT on FELL Street. After 1 mile, turn RIGHT on DIVISADERO ST. and continue to UCSF Medical Center at Mount Zion.

From the San Francisco Airport and South Bay (Highway 101, I-280): As you approach San Francisco, stay in the left lane and follow the signs for "101 NORTH/GOLDEN GATE BRIDGE." EXIT to the left on

"101 NORTH/GOLDEN GATE BRIDGE." Get in the left lane and EXIT on "OCTAVIA BLVD/FELL STREET." After 4 blocks, turn LEFT on FELL Street. After 1 mile, turn RIGHT on DIVISADERO ST. and continue to UCSF Medical Center at Mount Zion.

Parking: Please see the map above for parking.

Public Transportation: UCSF Medical Center at Mount Zion is accessible via Muni bus routes 2-Clement*, 38-Geary*, 4-Sutter, 24-Divisadero and 1-California (stop is 3 blocks north of the hospital at California St. and Divisadero St.). The free UCSF Shuttle Bus travels between Parnassus and Mount Zion and other UCSF locations. For more information please call (415) 476-1511.

* Wheelchair accessible bus routes

UCSF Medical Center
at Mount Zion

Fee Letter

Information pertaining to Health Insurance, Self-Pay Patients, and other Financial Matters

If you have an HMO or an IPO, it is your responsibility to provide either a referral or an authorization for your first appointment. Please talk to your referring provider about securing a referral or an authorization for you visit.

If a referral or an authorization is not obtained prior to your visit, you will be considered a self-pay patient and the fees described below will apply to the services you receive.

If you are a self-pay patient, meaning you do not have insurance or you are choosing not to use your insurance, a **deposit of \$345** will be collected from you when you check in to see the doctor for your first visit. This fee only covers your exam and conversation with the physician. If the physician performs any tests or does any procedures, you will be billed for those additional services. The deposit fee for future follow-up visits will be \$160.00. You will receive a bill for the balance of the charges based on the services provided during your office visit. UCSF automatically provides a 40% discount to all self pay patients.

If you are coming here for a second opinion, it is very common for the physician to request that any pertinent previous pathology slides and radiology films be reviewed here at UCSF. If your doctor suggests this as their plan, please be aware that charges for these evaluations can range from **\$400 to \$2500**. If you want an estimate prior to either the Department of Pathology or the Department of Radiology performing their review, please call (415) 353-1269 or (415) 353-1609 for Pathology and (415) 353-1236 for Radiology. You may be asked to make a deposit for these reviews in advance. Unfortunately, our staff at the Cancer Center do not have access to how the pricing is determined by these other departments and is unable to provide you with an accurate quote.

Many patients have insurance plans with deductibles. If your insurance plan has a deductible, UCSF will first bill your insurance plan and if you have not met your deductible, you will receive a bill for your medical services. The bill you receive will be at a reduced rate based on the allowable charges as defined by your insurance contract with UCSF.

If at any time you would like to speak to a financial counselor to see if any special arrangements can be made, please fax (415) 885-3505 or call (415) 885-7803.

Sincerely,

Cancer Center Staff

Radiology Information Sheet for Patients

What is the difference between the radiology report and the radiology films?

A report will cover the findings of the radiologist at the time your scan is taken. The films are the scan itself. When you come in for a new patient appointment, your doctor will usually want to see both the report and films.

What kind of format will the scans have?

Scans have traditionally been on oversized black translucent films but increasingly scans are being put on compact disks (CD ROM).

Isn't the radiologist's report enough? Why is my doctor requesting the films?

The physician will often review the radiologist's report as a starting place to plan your treatment. However, because you are being referred to our physicians who collaborate with the UCSF Radiology Department in planning your treatment, he or she will always request the radiology films be sent. The films are used to confirm the diagnosis and plan treatment.

How do I obtain the films?

You call the hospital or facility where you had the scan done. If you call a hospital, you will need to ask to be connected to the Radiology Department. Attached to this information sheet are numbers to many regional hospitals. UCSF prefers scans to be on CD ROMS but you need to ask the department to put the CD's into Di-Com format. The Radiology Department will often request that you sign a release for the films. Here is the link to the UCSF release form:

http://www.ucsfhealth.org/adult/patient_guide/services/health_info_release_form.pdf

This release can also be used for you to obtain your medical records or tissue slides.

What if I want a copy of my films?

If you would like a copy of your films, and your facility puts them on CD ROM, you must request **two copies**: one for you to keep and one to send to our Center. To protect your privacy, we destroy all CD ROMs after downloading into our Radiology system and are unable to return these to you. Copies of the large translucent films can be kept for you to pick up after your provider has completed reviewing them although sometimes they wish to keep them for further review sometimes several weeks or longer. Original large translucent films will be sent back to the facility.

What happens if the films are lost?

If a film were to get lost you can usually request a new copy from the facility where you had the scan done. However, you should always confirm with that facility that you are not taking the only remaining copy.

If I send scans to UCSF will there be additional fees?

When UCSF Radiology Department reviews the films for a second opinion they charge a fee. Typically, most insurance plans will cover this and our staff will seek an authorization.

What scans should I request?

Any scans related to the disease process for which you are being referred to us. These include: Bone Scan; Computerized Tomography (CT)' Magnetic Resonance Imaging (MRI);

Mammograms; Positron Emission Tomography (PET); and Standard X-rays such as chest x-rays. Please note that Ultrasounds may only be provided by report, there are no ultrasound films.

Do I need to provide Radiology Films for future follow up appointments?

Yes, if you continue to receive care at UCSF and you do not have your Radiology tests done at UCSF, you will need to send all Radiology films placed on a CD ROM reports done in-between your visits to the address above.

Radiology Departments for Bay Area Hospitals

Alta Bates Hospital

Radiology: 510-204-1564
Fax: 510-549-2671

Queen of the Valley

Radiology: 707-257-4064
Fax: 707-257-4169 or 707-257-4061

CPMC – California Campus

Radiology: 415-750-6025
Fax: 415-750-5000

San Francisco Open MRI

415-956-2525
Fax: 415-217-4535

Highland Hospital

Radiology: 510-437-4727
Fax: 510-437-5176

Santa Rosa Memorial

Radiology: 707-525-5295
Fax: 707-547-5456

Marin General Hospital

Radiology: 415-925-7309

Santa Rosa Radiology(Open MRI)

707-525-4040
Fax: 707-525-4095

Marin Imaging

415-461-9033

St. Luke's Hospital

Radiology: 415-641-6753

Novato Community Hospital

Radiology: 415-209-1500
Fax: 415-209-1501

Sutter Medical Center

Radiology: 707-576-4392
Fax: 707-576-4841

Petaluma Valley

Radiology: 707-778-2555
Fax: 707-778-2684

Sutter Warrack

Radiology: 707-523-7153
Fax: 415-925-7317

Disability Paperwork Instruction Sheet & Form

University of California,
San Francisco
1600 Divisadero Street,
San Francisco, CA 94115

Breast Care Center
Tel: 415.353.7070

Dysplasia Clinic
Tel: 415.353.7100

Endocrine Surgery
Tel: 415.353.7687

GI Surgery & Oncology
Tel: 415.353.9888

Gyn Oncology
Tel: 415.353.9600

Head & Neck Surgery
Tel: 415.885.7528

Melanoma Center
Tel: 415.353.9900

Orthopedic Surgery
Tel: 415.885.3800

Thoracic Surgery &
Oncology
Tel: 415.885.3882

Urologic Oncology
Tel: 415.353.7171

The completion of disability paperwork is a partnership between you the patient, the practice support staff, and the treating physician. Please review this instruction sheet carefully.

Please allow 10 days for the completion of disability forms from the date you provide the forms to the practice staff. If you mail your forms please indicate "Disability Form" on the envelope.

Our staff are not experts on disability benefits or processes. If you need assistance, please contact the Cancer Resource Center (415) 885-3693 and ask to speak with a member of the social work staff.

Patient Responsibility:

1. Provide a paper copy of disability forms.
 - a. Go to www.edd.cahwnet.gov/direp/diloc.htm to obtain information for State Disability Insurance including office locations, program information, and e-forms. You can also call 1-800-380-3287.
 - b. For private insurance companies, contact your insurance company directly for information and paper forms.
2. Complete **ALL** patient sections including name, address, and telephone number **AND** date and sign your disability form.
3. Send, Fax, or hand carry your disability form **along with this form** to the practice.
4. If you are requesting a **continuation** of disability, **also provide a copy of the previously completed disability paperwork.**

Complete the following information:

- Your name and Date of Birth _____
- Best phone number to reach you _____
- Name of your surgeon or Oncologist _____
- Diagnosis _____
- Date of Cancer Onset _____
- Date and type of surgery _____
- Date of hospitalization _____
- Current treatment Chemotherapy Radiation Hormone Other
- Duration of Disability Start date _____ Estimated End date _____
- Date you need paperwork returned _____
- How do we return the forms to you? Mail to Fax to You pick up at clinic

Please tell us any other information that would help us to complete your disability paperwork accurately.

UCSF Helen Diller Family
Comprehensive
Cancer Center

Daphne Stuart, LCSW
Clinical Social Worker
Helen Diller Family
Comprehensive Cancer Center

UCSF Medical Center
1600 Divisadero Street
San Francisco,
CA 94143-1725
tel: 415/885-7394
fax: 415/885-3638
email:
daphne.stuart@ucsfmedctr.org

Dear Melanoma Service Patients, Families and Friends:

Please allow me to introduce myself and to tell you about the social work services available to you at the UCSF Comprehensive Cancer Center.

I am the clinical social worker for the Melanoma Service. I am available to meet with you to discuss questions or concerns you may have about the way a cancer diagnosis has changed your life, including:

- **How to cope with the emotional impact of cancer:** support groups or individual counseling with a social worker, psychologist or chaplain
- **Family issues:** caregiving, role changes, talking to children, intimacy
- **Dealing with the financial impact of cancer:** work, disability, health insurance coverage, grant money available
- **Lodging and transportation questions**
- **How to navigate the healthcare system**

There are many programs available to assist you, some within the UCSF Cancer Resource Center (first floor behind the gift shop), and others in the community. We can talk about which programs will meet your specific needs.

A special resource is the **Melanoma Support Group which meets** the 3rd Monday of the month, 6:30-8:00 pm. Please call 415-885-7394 if you are interested in joining .

You and your family are not alone in the experience of living with cancer. I am happy to be an extra member of your support team during this time.

Please feel free to:

- **Call or email me for consultation on Monday, Wednesday or Thursday from 8:30am-3:30pm.**
- **Call me to make an appointment to meet in person.**

Sincerely,

Daphne Stuart, LCSW

Daphne Stuart, LCSW
Clinical Social Worker
UCSF Comprehensive Cancer Center
415-885-7394
daphne.stuart@ucsfmedctr.org



A Comprehensive Cancer
Center Designated by the
National Cancer Institute

UCSF Medical Center

PATIENT FINANCIAL ASSISTANCE NOTICE

UCSF Medical Center is committed to providing you with the best medical care within the capabilities of this hospital's staff and facilities, regardless of your ability to pay.

UCSF Medical Center will provide emergency services, examination and/or treatment to you if you request such (or if someone requests such on your behalf) or if you are a woman in labor – regardless of your ability to pay for these services – so long as appropriate facilities and qualified personnel are available. You will be screened to evaluate your emergency condition and receive any necessary stabilizing treatment, including treatment for an unborn child.

Race, color, national origin, religion, sex, gender identity, pregnancy, physical, mental or other disability, medical condition, ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran, insurance coverage, economic status or ability to pay will not be considered in providing emergency service or care. However, some of these factors may be considered if they are important in providing appropriate medical care.

If you seek non-emergency services or post-emergency treatment, but are unable to pay, UCSF Medical Center offers financial assistance upon request. Financial assistance, including discounts and charity care, is available to individuals who meet eligibility criteria. Please ask to speak to a financial counselor or call the Financial Counseling Department at (415) 353-1966 to find out if you qualify for discounts or charity care.

If you do not have insurance or health plan coverage, and you agree to accept full financial responsibility for your hospital admission or outpatient services and promptly pay all resulting charges, UCSF Medical Center will offer you a 30% discount on your billed charges.

You may ask for a copy of our charge description master (CDM) if you have any questions about medical care charges. A list of twenty-five commonly charged services and procedures is also available to you in the Admitting Office or any registration area.

If you have any questions concerning the financial assistance policy, please speak to a Financial Counselor or contact the Financial Counseling Manager at (415) 353-1909.

UCSF Medical Center participates in the Medicare Program.

If you have any complaints about the services at UCSF Medical Center, you may contact:

The Joint Commission
Office of Quality Monitoring
(800) 994-6610
(M-F 8:30 am to 5:00 pm, Central Time)
complaint@jointcommission.org

California Department of Public Health
Licensing and Certification
(650) 301-9971
(800) 554-0353

**THANK YOU FOR CHOOSING UCSF MEDICAL CENTER
FOR YOUR HEALTH CARE NEEDS**

COLLABORATING

Working together with other UCSF departments, the **Ida and Joseph Friend Cancer Resource Center** partners to bring additional high-quality programs and services to our community. The following are just some of the excellent services we can help you access.

- ◆ Art for Recovery
- ◆ Osher Center for Integrative Medicine
- ◆ Fishbon Medical Library
- ◆ Tobacco Education Center
- ◆ Psycho-oncology
- ◆ Social Work
- ◆ Symptom Management
- ◆ Spiritual Care
- ◆ Patient Navigators
- ◆ Survivorship
- ◆ Friend to Friend Specialty Gift Shop
- ◆ And many others...

The **Cancer Resource Center** aligns itself with UCSF Medical Center's mission of Caring, Healing, Teaching and Discovering, by providing unique, hands-on volunteer opportunities for pre-health science students and anyone interested in learning about cancer supportive care. Cancer survivors may also find volunteering with current cancer patients a healing experience. To inquire, please call 415-885-3693.

CONTACT US

**Ida & Joseph Friend
Cancer Resource Center**

1600 Divisadero Street, Room B101

San Francisco, CA 94143-1725

Phone: 415-885-3693

Fax: 415-885-3701

cancerresourcecenter@ucsfmedctr.org

<http://cancer.ucsf.edu/crc>

OTHER DEPARTMENTS:

Art for Recovery 415-885-7221
Nutrition 415-885-7608
Psycho-Oncology 415-353-7019
Social Work 415-353-7982
Symptom Management . . . 415-885-7671

We are grateful to the organizations and individuals that provide support to our programs and services. Special thanks to the Donna Smith Endowment at UCSF, the Mount Zion Health Fund, and the Auxiliary of the Mount Zion Medical Center at UCSF.

As a nonprofit we rely on the generosity of patients, friends, survivors, community organizations, and foundations to fund our programs and services. To make a donation, please contact us at 415.885.7604.

UCSF Helen Diller Family
Comprehensive
Cancer Center

CONNECTING CARING COLLABORATING

The Ida and Joseph Friend
Cancer Resource Center
at the
**UCSF Helen Diller Family
Comprehensive Cancer Center**

**PROMOTING
WELLNESS & THE
HEALING PROCESS.**

CONNECTING

The **Ida and Joseph Friend Cancer Resource Center** is a nonprofit organization committed to promoting wellness and the healing process by providing patients, families and their friends with cancer supportive care services. We offer a range of programs, many are free to anyone living with cancer, regardless of where care is received.

- ◆ Peer support connecting a newly diagnosed patient with a cancer survivor
- ◆ Over 20 cancer support groups and referrals to 500 other groups in the Bay Area
- ◆ Nutrition counseling for UCSF cancer patients to cope with the many issues surrounding a cancer diagnosis
- ◆ Meditation & guided imagery classes
- ◆ Workshops, lectures and special events for cancer patients and their families
- ◆ Comfortable sitting area to relax, peruse our library, use our computer or enjoy a hot cup of tea.

CARING

Our services are aimed at helping patients increase quality of life during the stressful period from diagnosis through recovery and into survivorship.

- ◆ Medical appointment planning to assist patients in organizing their questions
- ◆ Free hand-knitted hats and scarves
- ◆ Referral services to over 1000 cancer resources in the Bay Area
- ◆ Nutrition workshops presented by a UCSF registered dietician
- ◆ Specialized lending library with books and CDs
- ◆ Up to date internet guide
- ◆ Free educational pamphlets on cancer, symptom management, coping, and caregiver resources.
- ◆ Movement and exercise classes
- ◆ Weekly knitting gatherings.

UCSF Medical Center

Patient Health Library at Mount Zion



The place for finding health & medical information.

- Consult a professional medical librarian
- Internet access
- Daily newspapers, health newsletters
- Copier, fax, scanner

Monday – Friday, 9:00am – 5:00pm

1600 Divisadero Street – 1st floor, A Building
San Francisco, CA 94115
415.885.7285
patientlibrary@ucsfmedctr.org

<http://mountzion.ucsfmedicalcenter.org/phl>

A branch of the
H.M. Fishbon Memorial Library
UCSF Medical Center at Mount Zion



Health Information on the Internet

UCSF Medical Center Health Information Online

Medical Center Health Library *and* UCSF Benioff Children's Hospital

- Conditions & treatments
- Patient education
- Medical dictionary
- Medical tests
- Clinical trials
- Research at UCSF

<http://www.ucsfhealth.org>
<http://www.ucsfbenioffchildrens.org>

MedlinePlus

- Diseases & conditions
- Medical encyclopedia
- Medical dictionary
- Links to reliable web sites
- Drugs, herbs & supplements
- Interactive tutorials
- Videos of surgeries
- Current health news
- Directories
- Clinical trials

<http://www.medlineplus.gov>

National Cancer Institute

- In-depth information for patients & professionals
- Treatment by cancer type
- Prevention, genetics, causes
- Screening & testing
- 1-800-4-CANCER
- Coping & support
- Dictionary of cancer terms
- NCI drug dictionary
- Clinical trials
- Statistics
- LiveHelp® online chat

<http://www.cancer.gov>