PATIENT INFORMATION

Welcome to our office.
In order to serve you properly, we need the following information. All information is strictly confidential.

Today's Date:

PATIENT INFORMATION

Patient's last name: First: | Middle: | Marital status:

Is this your legal name? ◌ Yes ◌ No | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: ◌ M ◌ F

Address:

Social Security no.: | Home phone no.: | Cell phone no.:

Occupation: | Employer: | Employer phone no.:

Name of Spouse (or Parent/Guardian)

INSURANCE INFORMATION

Person responsible for bill: | Birth date: | Address (if different): | Home phone no.:

Is this person a patient here? ◌ Yes ◌ No | Is this patient covered by insurance? ◌ Yes ◌ No

Occupation: | Employer: | Employer address: | Employer phone no.:

Please indicate primary insurance: Other:

Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.:

FINANCIAL

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Gautam to release any information required to process my claims.

Patient/Guardian signature ______________________ Date ______________________

I understand that I am financially responsible for all charges for services to me including the balance remaining after payment of possible insurance benefits.

Patient/Guardian signature ______________________ Date ______________________

Adult TB Exposure Risk Assessment

(Evaluation Questionnaire to determine if Tuberculin Mantoux skin test (TST) is indicated)

Name: ________________________ **Medical Record #:**_____________________________

Age: ____________ **DOB:** ___________________ **Date of Service:** ____________________

The health care worker (HCW) is to ask the following questions during each periodic health assessment:

1. Have you or anyone you see regular been diagnosed or suspected of being sick with active diseases?
   Yes______ No______
2. Do you have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?
   Yes______ No______
3. Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?
   Yes______ No______
4. Do you live in out of home placements (such as foster care or residential facilities?
   Yes______ No______
5. Do you have HIV infection or other immunosuppressive condition(s)?
6. Do you live with someone with HIV seropositivity?
   Yes______ No______
7. Do you live or frequently visit with persons who have been incarcerated in the last 5 years?
   Yes______ No______
8. Do you live among or been frequently around individuals who are homeless, migrant workers, user of street drugs, or residents in nursing homes?
   Yes______ No______
9. Do you consume alcoholic beverages?
   Yes______ No______

INSTRUCTIONS TO HEALTH CARE WORKER:

Administer the Mantoux TB skins test to all adults who have any of the above risk facts (indicated by YES response) UNLESS

1. The patient has previously **DOCUMENTED*** positive Mantoux TST, or
2. The patient has had a TST within the last year.

Note:
Trained medical personnel must read the skin test.
***DOCUMENTED** = Record indicated date of Mantoux and the millimeter results.

Health Care Worker completing form: ____________________________________

Date: ____________________________

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name ______________________________ **Today's Date** ______________

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

1. DEPRESSED MOOD
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

2. FEELINGS OF GUILT
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

3. SUICIDE
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

4. INSOMNIA - Initial
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

5. INSOMNIA - Middle
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

6. INSOMNIA - Delayed
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

7. WORK AND INTERESTS
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

8. RETARDATION
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

9. AGITATION
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

10. ANXIETY - PSYCHIC
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

☐ **11. ANXIETY - SOMATIC**
Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ **12. SOMATIC SYMPTOMS - GASTROINTESTINAL**
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

☐ **13. SOMATIC SYMPTOMS - GENERAL**
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

☐ **14. GENITAL SYMPTOMS**
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

☐ **15. HYPOCHONDRIASIS**
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

☐ **16. WEIGHT LOSS**
0 = No weight loss
1 = Slight
2 = Obvious or severe

☐ **17. INSIGHT**
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: ______________
0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
$\geq$ 23 = Very Severe Depression

☐ **18. DIURNAL VARIATION**
(Symptoms worse in morning or evening. Note which it is.)
0 = No variation
1 = Mild variation; AM (   ) PM (   )
2 = Severe variation; AM (   ) PM (   )

☐ **19. DEPERSONALIZATION AND DEREALIZATION**
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ **20. PARANOID SYMPTOMS**
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

☐ **21. OBSESSIONAL SYMPTOMS**
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry*. 23:56-62, 1960.

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

#	Question				Topic
21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	
☐ Independent Living	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

FALL RISK ASSESSMENT FORM

Resident Name-			Rm-
Check off reason for assessment			
Initial Assessment		Re-Assessment after fall	
Re-Assessment (periodic)		Change in Status	
Categories	**Circle reference number(s) in each category**	**Descriptions**	**Total reference numbers by category**
Recent Fall History	0	NO FALLS in past 3 months	
	2	1 - 2 FALLS in past 3 months	
	4	3 OR MORE FALLS in past 3 months	
Ambulation / Continence	0	AMBULATORY/CONTINENT	
	2	CHAIR BOUND - Requires assist with elimination	
	4	AMBULATORY/INCONTINENT	
Mental Status	0	ALERT (oriented X 3) OR COMATOSE (no voluntary or involuntary movement)	
	2	DISORIENTED X 3 at all times	
	4	INTERMITTENT CONFUSION / forgets limitations	
Vision	0	ADEQUATE (with or without glasses)	
	2	POOR (with or without glasses)	
	4	LEGALLY BLIND	
Balance	To assess, have resident stand on both feet without holding onto anything; walk straight forward; walk through a doorway; and make a turn.		
	0	Gait/Balance normal	
	1	Balance problem while standing	
	1	Balance problem while walking	
	1	Decreased muscular coordination	
	1	Change in gait pattern when walking through doorway	
	1	Unstable when making turns	
	1	Requires use of assistive devices (i.e., cane, w/c, walker, furniture)	
	1	Inappropriate use of assistive device / footwear	
Blood Pressure (Systolic)	0	NO NOTED DROP between lying and standing	
	2	Drop LESS THAN 20 mm Hg between lying and standing in 3 minutes	
	4	Drop MORE THAN 20 mm Hg between lying and standing in 3 minutes	
Medications	Diuretics (somnolence, volume depletion, electrolyte disturbance, urgency to rush to bathroom), Psychoactives: Benzodiazepines (i.e. Ativan, Halcion), Phenothiazines, Antidepressants, and antipsychotics (i.e., Mellaril and Haldol), Narcotics, Anticonvulsant stabilizers, Cardiovascular medications, Corticosteroids (can adversely effect muscle function), or any medication that adversely affects muscle function, coordination, and physical stability.		
	0	NONE of these medications taken currently or within last 7 days	
	2	TAKES 1 - 2 of these medications currently and/or within last 7 days	
	4	TAKES 3 - 4 of these medications currently and/or within last 7 days	
	1	If resident has had a change in medications and/or change in dosage in the past 5 days = score 1 additional point	
Predisposing Conditions or Diseases	Gastrointestinal: Bleeding, Diarrhea, Defecation Syncope, Postprandial Syncope, Genitourinary: Micturition syncope, Incontinence, Nocturia (80% of the elderly experience nocturia and going to the bathroom at night is a major risk factor), Cardiovascular: Myocardial infarction, Arrhythmia, Orthostatic Hypotension, Musculoskeletal disorders: Arthritis, Inflammatory Joint Disease, Osteoarthritis Proximal Myopathy, Deconditioning, Neurologic: Parkinsonian, Dementia, Stroke, Transient Ischemic Attack, Delirium, Myelopathy, Vertebrobasilar Insufficiency, Carotic Sinus Supersensitivity, Cerebellar Disorder, Peripheral Neuropathy, Diabetes, B12 Deficiency, Multiple Myeloma, Vasculitis, Chronic dehydration		
	0	NONE PRESENT	
	2	1 - 2 PRESENT	
	4	3 OR MORE PRESENT	
A TOTAL SCORE OF 10 OR MORE INDICATES A RESIDENT "AT RISK" FOR FALLS.		**TOTAL SCORE--->**	

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-NY-AIM7.2-11-04

RAVINDRA M. GAUTAM, MD, INC

ADVANCE DIRECTIVE ACKNOWLOGEMENT FORM

I acknowledge that I have received information on Advance Directive policy.

__________________________________ ____________________

Patient/Patient Representative Signature Date

I do not have an Advance Directive. Information has been offered to me.

__________________________________ ____________________

Patient/Patient Representative Signature Date

I have an Advance Directive and will bring it on another day.

__________________________________ ____________________

Patient/Patient Representative Signature Date

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for –

Items or Services:

Office Visit

Because:

Office Visit

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't under stand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**________________), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

______________________ ____

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)