St. Luke's HOSPITAL

232 South Woods Mill Road
Suite 330 3rd Floor East Medical Bldg
Chesterfield, Missouri 63017
Phone: (314) 205-6737
Fax: (314) 576-2378

Physicians' Exchange
(314) 364-5240
[toll free] (877 998-6489

Welcome to the Center for Cancer Care at St. Luke's Hospital

The Center for Cancer Care at St. Luke's Hospital offers comprehensive outpatient services, educational information and emotional support for the prevention, diagnosis and treatment of cancer. The Cancer Center is committed to the lives and welfare of all who entrust us with their care. We will respectfully treat you as a person with unique needs and concerns. We will help educate and support you and your family during your treatment. We will help you make informed choices about your treatment plan and support your decisions.

The Cancer Center has a team approach to taking care of you. Our highly trained staff of physicians and nurses work together to diagnose, evaluate, develop, and manage your care before, during, and after your treatment.

The Center for Cancer Care houses the medical oncology offices, chemotherapy infusion area, radiation oncology offices, laboratory, complementary services and the Cancer Resource Center. The Cancer Resource Center contains information about cancer diagnosis and treatment options with the most recent books and literature including on-line access. The Center for Cancer Care provides:

Diagnosis:

- Mammography services
- Breast Care Center
- Radiology services
- Research
- Cancer Registry

Treatment:

- Radiation Oncology
- Infusion Center
- Medical Oncology
- Surgery

Education and Support:

- Cancer Resource Center
- Dietitian
- Support groups
- Community Outreach
- Physician Referral services
- Oncology Rehab Program
- Survivorship Program
- Cancer prevention and education
- Palliative care
- Hospice care
- Pastoral care and chaplain services
- Social Services

Office Hours

The physician office hours are Monday through Friday, 8:00am - 4:30pm, and the Cancer Infusion Center is open Monday through Friday, 8:00am - 6:00pm with the exception of holidays. All infusions are to be completed by 6:00pm.The Medical Oncology office phone number is 314-205-6737. The infusion room number is 314-542-4793.

Emergencies

For any problems or emergencies, you may reach our exchange at 314-364-5240 or toll free at 877-998-6489 and one of our physicians will return your call promptly. You can expect a call within 30 minutes. If you have not received a call within one hour, please call the exchange again.

If you feel that your problem requires immediate attention, please go to the St. Luke's Emergency Room or your closest emergency room.

Parking

Parking is available in the East parking garage and adjacent parking lots. There are spaces designated for "Cancer Center Patients Only" on the first level and third level of the garage. There are handicap spaces on all levels of the garage and in the adjacent lot. Free valet parking is available for your convenience. The valet is located at the entrance to the East Medical Building. This service is provided Monday through Friday from 7:30 am until 4:00 pm.

Office Visits

The lab is located on the first floor of the East Medical Building, Suite 120. You will usually be asked to go to the lab prior to each office visit, as well as on some of your weeks off. **PLEASE NOTE:** If your insurance requires you to get your labs drawn at Quest or LabCorp, you will need to have them drawn *on the day prior* to your scheduled office visits.

Upon completion of your lab work on your scheduled office visit days, please go to the 3rd floor Physician Offices, located in Suite 330 of the East Medical Building. Please register with the receptionist at the check-in desk. Your physician will meet with you, perform an examination, evaluate your status and review your current test results. They will release you to check out of the office, then into the infusion room for your scheduled treatment if appropriate. You will receive an arm band which will be required for your treatment.

If you need to be seen for an unscheduled visit, please make every attempt to call the office in the morning and speak with your Care Coordinator first to discuss your problems, and to set up an appointment time. If you arrive at the office without an appointment, we may not be able to see you promptly as there are previously scheduled patients waiting to be seen. **In a true emergency, please go directly to the St. Luke's Hospital Emergency Room.**

Symptom Management & Prescriptions

The Care Coordination Team is available Monday through Friday 8:00am to 4:30pm. You will be assigned a RN Care Coordinator to help with any problems, questions or concerns you may have. Lab results will be given as time permits, and may be done later in the day, or the next day if results are not back yet or the physician has not reviewed the labs. Please be aware that we will not give out results of tests ordered by other physicians providing care to you.

Prescription refills should allow 48 hours for processing. Try to monitor refill needs and allow adequate time for refills. **If you are on any pain medication, please make sure you have enough for weekends. Please try not to call on Friday afternoons for refills of medications that require a paper prescription to be picked up. If your prescriptions have been given by your primary care physician or other physicians who are caring for you, please notify their office for the appropriate refills.

Treatment planning

Once your physician has evaluated your medical conditions, he/she will recommend treatment options. Our Nurse Coordinator Team will assist you with setting up your treatment schedule and initiation of treatments. The front desk staff will ask you to provide alternate telephone numbers to reach you if your treatment time must be changed or if there is a problem with scheduling. You will also be asked to provide the front desk staff with your pharmacy phone numbers, so that we will be able to promptly fill any prescriptions that are required for your treatments.

The Nurse Coordinator Team will set up your initial treatment appointment. Future appointments will be set up by the scheduler in the treatment room. Your schedule will include physician office visits, lab appointments, and treatment appointments. We will try to accommodate your scheduling requests as much as possible but most treatments need to be kept on the same day of the week and your appointment time will probably change with each visit as we are coordinating multiple appointments for you, with multiple divisions within our center, so flexibility is limited. It is very helpful if you work with us to schedule short treatments in the afternoon, as long treatments need to be scheduled in the early and late mornings.

If you have a need to change a treatment appointment please call the treatment room at 314-542-4793 and the scheduler will assist you. The scheduling nurse may ask for alternate telephone numbers to reach you if needed to change treatment times or cancel a treatment visit. If you need to change a physician's appointment only, you may call the front desk number at 314-205-6737 and that staff will assist you.

We will provide you with a printed schedule of your appointments. These may have times for your lab visits, your physician, and your treatment.

INFUSION ROOM GUIDELINES

In an effort to provide comfort and safety to our patients and visitors, we ask that you observe the following:

- Visitors are limited to **one** visitor per patient in the treatment area. Exceptions to this are during teaching/education sessions and/or special circumstances.
- Visitors must be **at least 16** years old to enter the treatment area. Exceptions to this are during teaching/education sessions and/or special circumstances.
- **Pregnant women** are **not allowed** in the infusion center for their protection, unless they are being treated.
- Recliners are reserved for patients undergoing treatment.
- Snacks and beverages are available for **patients**.
- Private rooms are reserved for patients with **special needs** and/or circumstances
- Please **be courteous** to the other patients around you at all times.

Infusion Room Wait Time

Although every effort is made to keep wait times down to a minimum, patient safety is of the utmost importance when dealing with complicated medications such as chemotherapy and biological agents. It is important to understand that there are several safety protocols in place to ensure that each patient receives appropriate, safe, and excellent care. It is reasonable for most patients to expect up to a 45 minute wait in the chair before treatment is started, and in all cases, we cannot begin to prepare for treatment until you are here, assessed by the nurse, and venous access is obtained if necessary for your treatment. If your wait time is prolonged, your nurse will keep you updated as to why you are waiting.

Lastly, thank you for allowing us to participate in your care. The health and well being of our patients and visitors is of the utmost importance to us.

Patient Rights

All patients and/or designated representatives have the following rights:

- To be treated with dignity, compassion, courtesy and respect by all who provide services.
- To receive care that is continuous, coordinated and administered in the appropriate setting, and which respects your personal values and beliefs.
- To have nondiscriminatory access to treatment accommodations to the extent that they are available and medically necessary, regardless of gender identity, sex, race, color, creed, mental or physical disability, disease process, national origin or source of payment for care.
- To utilize any alternative means of communication, when medically indicated, for hearing or visually impaired patients, as well as obtaining a translator for patients who speak a language other than English.
- To participate in and make informed decisions regarding your care.
- To be informed about the outcomes of care, including unanticipated outcomes.
- To receive current information on your diagnosis healthcare status, treatment, alternative choices, risks and prognosis to decide whether to accept or refuse available care.
- To request or refuse treatments, medication or procedures and be informed of the medical consequences of your decision.
- To participate or refuse to participate in medical research and to have any research fully explained to you.
- To participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, forgoing or withdrawal of life-sustaining treatment and care at the end of life.
- To receive appropriate assessment and management of pain.
- To make healthcare directives and to have healthcare professionals honor the directives within the limits of the law and the hospital's mission, philosophy and capabilities.
- To designate a decision maker while you are still able to do so or in the event you are incapable of understanding a proposed treatment or procedure or are unable to communicate your wishes regarding care.
- To utilize hospital resources, such as the patient relations representative, chaplains, social workers, financial counselors or Ethics Committee members, who can assist you with concerns and answer questions about your stay and care.
- To participate in the development and implementation of his/her plan of care, to be actively involved in the development of a discharge plan including being informed of service options that are available and a choice of agencies that provide service.
- To have a family member or representative and your physician notified promptly of your admission to the hospital.
- To request that information about your presence at St. Luke's not be made available to the public.
- To know the identity and professional status of the people who are caring for you.
- To decide who will/will not participate in your care: healthcare workers, family and others.
- To choose a doctor other than the one who currently cares for you, at your request and expense.
- To receive treatment and services that you need or request, that are within the ability of St. Luke's to provide. If St. Luke's cannot provide the service, you will be informed of the need to transfer to another facility and the alternatives to such a transfer.
- To expect a reasonable response to requests for treatment/service.
- To complain about treatment or care, have your complaints reviewed and resolved, if possible, without compromising your care or access to service.
- To examine and receive an explanation of hospital charges.
- To receive care in a safe setting.
- To be free from any form of abuse or harassment.
- To be free from restraints of any form that are not medically necessary.
- To receive assistance in obtaining protective services.
- To have personal possessions brought to the hospital reasonably protected.
- To exercise the following rights regarding your health information:
  - Be assured personal privacy, security and the appropriate confidentiality of your personal medical records.
  - Access information in your medical record and to receive photocopies for a reasonable fee;
  - Request restrictions on the way we use your medical information;
  - Request to receive information from us in a different way or manner;
  - Review your medical information;
  - Request that we amend your medical information;
  - Know how we have used or disclosed your medical information;
  - Revoke your authorization to use or disclose health information except to the extent that action has already been taken;
  - Obtain a paper copy of the Notice of Privacy Practices upon request.
- To participate in patient visitation:
  - To be informed of visitation rights, including any clinical restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation.
  - To consent to receive designated visitors including, but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.
  - To ensure that all designated visitors have visitation privileges that are no more restrictive than those that immediate family members would enjoy.
  - To not have visitation privileges restricted on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability.

Complaints or Grievances

St. Luke's Hospital recognizes and affirms the rights of patients or their representatives to express concerns about care, service or hospital length of stay without compromising care or access to service. If you or your representative wish to lodge a complaint or grievance, contact the manager of the department or service, or the Patient Relations Representative at 314-205-6655, or the Hospital Administration at 314-205-6930. Patients or their representatives may also lodge a complaint or grievance with the Missouri Department of Health and Human Services at 1-573-751-6303, P.O. Box 570, Jefferson City, Missouri 65102. You can also contact The Joint Commission at complaint@jointcommission.org or Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL, 60181. Medicare beneficiaries may also contact the state quality improvement organization, Primaris, to lodge a complaint or grievance at 1-800-735-6776. It is not required that complaints/grievances be lodged with the hospital's grievance process before one is lodged with the Missouri Department of Health and Human Services or with Primaris.

St. Luke's HOSPITAL

Our specialty is you.

St. Luke's HOSPITAL
Our specialty is you
232 S. Woods Mill Road
Chesterfield, MO 63017

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to St. Luke's Hospital, Surrey Place, St. Luke's Pediatric Care Center, Vascular Access Center, St. Luke's Urgent Care Centers and Convenient Care, St. Luke's Home Health Services, St. Luke's Hospice Services and St. Luke's Medical Group.

Protection of Protected Health Information (PHI): Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) St. Luke's Hospital is required by law to keep protected health information (PHI) private. PHI is any health information that identifies you, including information such as your name, address, telephone number, and any information created by your healthcare providers for treatment, billing or payment. St. Luke's is committed to the protection of your PHI and will make reasonable efforts to keep your PHI confidential as required by law. St. Luke's is also required to provide you with this notice of our privacy practices. We take this commitment seriously and will work with you to comply with your right to receive certain information under HIPAA.

Understanding Your Health Record/Information: This notice applies to all of the records of your care at St. Luke's Hospital and will tell you about the ways in which we may use and disclose your medical information. This notice will also describe your rights and certain obligations St. Luke's has regarding the use and disclosure of medical information.

Standard Use and Disclosure of Your Medical Information: St. Luke's and physicians with staff privileges may use your medical information to provide you with medical treatment and services, to receive payment for those services, and in daily health care operations in the following ways without your permission:

Treatment: St. Luke's may disclose your medical information to those involved in your treatment on an as-needed basis. *For Example: We may share medical information with healthcare providers across all St. Luke's locations.*

Payment: St. Luke's may be required to use or disclose your medical information for payment or billing purposes. *For Example: When St. Luke's Hospital submits bills to an insurance company, Medicare, another health care agency or an employer, they require a listing of your diagnoses, procedure as well as a listing of services/supplies you received from St. Luke's in order for St. Luke's Hospital to receive payment for those services.*

Health Care Operations: St. Luke's Hospital may also use and disclose your medical information in our everyday health care operations. *For Example: Your medical information may be used to assist us in evaluating our performance in providing your healthcare.*

Business Associates: St. Luke's Hospital may disclose PHI to its business associates to perform certain business functions or provide certain business services to St. Luke's Hospital. *For Example: We may use another company to perform billing services on our behalf. All of our business associates are required to maintain the privacy and confidentiality of your PHI.*

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent:
St. Luke's may also share your medical information without your permission for the following reasons:

Public Health activities: To prevent or control disease, report birth or death, and for the purpose of public health investigations, interventions, and other related matters.

Government Authorities: Reporting medical information as required by law about persons who may be victims of abuse, neglect, or domestic violence.

Oversight Activities: Reporting information to agencies that oversee insurance health benefit programs for the purpose of audits, investigations, inspections, or other activities.

Workman's Compensation: Disclosing information necessary to comply with Worker's Compensation laws or purposes.

Administrative Proceedings: Releasing information in response to a court order or subpoena in a judicial or administrative proceeding.

Law Enforcement: Cooperating with law enforcement officials for law enforcement purposes in the following situations: when required by law; for identification and location purposes; if you are suspected to be a victim of a crime; to report suspicion of death by criminal conduct; to report suspicion of criminal conduct occurring on the grounds of our facility; and in the case of an emergency.

Coroner, Medical Examiner, Funeral Director: Releasing information to a coroner, medical examiner, or funeral director in the event of your death.

Organ and Tissue Donation: Sharing information with organ/tissue donation organizations in the event of your death.

Prevention of an Immediate Health or Safety Threat: To prevent an immediate threat to the health or safety of the public limited health information may be disclosed if necessary.

Research: Disclosing information related to a research project when a waiver of authorization has been approved by the Investigational Research Body (IRB).

Special Government Circumstances: Involving military or veterans activities; national security and intelligence activities; protective services for the President; medical suitability determinations; law enforcement custodial situations; and government programs providing public benefits.

Military Command Authorities: If you are a member of the armed forces (or if foreign military personnel, to appropriate foreign military authorities).

Prison Inmates: Information can be released to the correctional facility in which the inmate resides for the following purposes: 1) for the correctional facility to provide the inmate with healthcare; 2) to protect the health and safety of the inmate or the health and safety of others; or 3) for the safety and security of the correctional facility

Food & Drug Administration (FDA) or the Center for Disease Control (CDC): To report adverse events with respect to immunizations and or health screening tests.

Employers of Food Handlers (Hepatitis A Ordinance NO. 19,770,199): To provide proof of Hepatitis A vaccinations as required by the County Council of St. Louis County, Missouri.

St. Luke's may also share the following information with you about products/services that are related to your treatment without an authorization:

- *Products/services that pertain to care coordination or case management.*
- *Recommendation of alternative treatments, therapies, health care providers or settings of care.*
- *Small promotional items.*
- *Face-to-face communications.*
- *Prescription refill reminders*
- *Other* uses and disclosures not described in this Notice of Privacy Practices.

Uses and Disclosures That Require Your Consent:

Your consent is required for the following uses and disclosures and will be made only with written authorization from you:

- **Marketing:** We must have your written permission before we can accept payment for the use and disclosure of your PHI for marketing purposes.
- **Sale of PHI:** We cannot sell your PHI without your written permission, except we may be paid our costs (i.e. labor, supplies, postage) to provide PHI to public health/other purposes permitted by HIPAA.

To send your written authorization to St. Luke's Hospital, refer to the "**Contacting St. Luke's Hospital"** section at the end of this notice.

*You may revoke your written authorization in writing at any time unless the authorization was obtained as a condition of obtaining insurance coverage. If you revoke your authorization, we will not be able to take back any disclosures that we have already made. Refer to the "**Contacting St. Luke's Hospital"** section at the end of this notice.*

Planned Uses or Disclosures to Which You May Object:
Unless you object in writing to the Privacy Officer at St. Luke's Hospital, St. Luke's will also use or disclose your health information for purposes described in this section. Refer to the "**Contacting St. Luke's Hospital"** section at the end of this notice.

- **Appointment Reminders**
- **Hospital Directory:** Directory information includes your name, location in the Hospital, and your general condition. We may disclose hospital directory information to people who ask for you by name, which may include your name, room number and general condition. *For Example, stable, critical, etc*. If you do not wish to be listed in our hospital patient directory please let the registrar/your nurse know as soon as possible.
- **Disaster Relief:** Provide information to a public or private entity that is authorized by law or its charter to assist in disaster relief efforts; i.e. the American Red Cross for the purpose of notification of family and/or friends of your location and condition.
- **Health Information Exchange (HIE):** Access/share your prescription information through a HIE. St. Luke's participates in an HIE that will make your prescription information available to other healthcare providers who may need access in order to provide your care or treatment. St. Luke's may electronically access and disclose prescription information to these exchanges.
- **Fundraising:** If St. Luke's sends fundraising communications to you; you have the right to opt out of such fundraising communications.

Your Rights: You have the right to:

- ***Request a Restriction:*** You may request a restriction on the protected health information that St. Luke's Hospital uses or discloses about you for payment, treatment or

health care operations using the ***"Contacting St. Luke's Hospital"*** section of this notice. You have the right to request a limit on disclosures of your PHI to family members or friends who are involved in your care or the payment for your care. St. Luke's may disclose information about you that is directly relevant to any member of your family, or to a designated caregiver of yours, if that person is involved with your care or the payment for your care. St. Luke's may also use or disclose your health information to notify, identify or locate a family member, or other person responsible for your care, of your location, condition or death. If you pay in full for a health care item or service out-of-pocket and request that St. Luke's Hospital not disclose PHI about that health care item/service to your health plan, St. Luke's Hospital will not disclose PHI about that service to the health plan unless we are required to do so by law. It is your responsibility to alert St. Luke's if this is your intention **before** the health care item or service is performed so that written authorization can be obtained and full payment can be collected at that time.

- ***Request Confidential Communication:*** You may request to receive your PHI by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. *For Example: You may only want to have PHI sent by mail or to an address other than your home.* While we are not required to agree to all requests, St. Luke's Hospital will accommodate all reasonable requests for confidential communications. For more information about exercising these rights, contact the Privacy Officer using the ***"Contacting St. Luke's Hospital"*** section of this notice.

- ***Request Access:*** You have the right to inspect and have a copy of your PHI in paper or electronic format. You must submit your request in writing by completing the "Authorization for Use and Disclosure of PHI" form available at stlukes-stl.com under "Patients & Visitors," or you may request the form be mailed or faxed to you by calling St. Luke's Health Information Services Department at 314-205-6186.

- ***Request an Amendment:*** You have the right to request an amendment of your PHI held by St. Luke's Hospital if you believe that information is incorrect or incomplete. Your request must be in writing and sent to the Privacy Officer using the ***"Contacting St. Luke's Hospital"*** section of this notice and must give a reason(s) in support of the proposed amendment.

  In certain cases, St. Luke's may deny your request for an amendment. *For Example: St. Luke's may deny your request if the information you want to amend is accurate and complete or was not created by St. Luke's.*

  If St. Luke's denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- ***Request an Accounting of Disclosures:*** You have the right to request an accounting of certain disclosures St. Luke's Hospital has made of your PHI. You may request an accounting using the "***Contacting St. Luke's Hospital"*** section of this notice. You can request an accounting of disclosures made up to six years prior to the date of your request.

- ***To be Notified of a Breach:*** You have the right to be notified in the event that St. Luke's (or their Business Associate) discovers a breach (unauthorized or inadvertent) release of PHI

- ***Right to a Paper Copy of This Notice:*** You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

Ch*anges to this Notice:* St. Luke's has the right to change this notice. Changes may be effective for any current health information about you and any information that may be obtained in the future. Changes to this notice will also be effective for all health information St. Luke's maintains about you. The most recent copy of this notice will be on our website and available anywhere you register for services. You can also contact the St. Luke's Privacy Officer to obtain the most recent copy of this notice.

To Report a Privacy Concern: St. Luke's Hospital takes the privacy and security of your protected health information very seriously. If you believe that your privacy rights have been violated please contact St. Luke's Privacy Officer so we may investigate and try to correct the problem. You also have the right to file a complaint with the Department of Health and Human Services. St. Luke's will not treat you differently or prevent you from receiving care if you decide to report a complaint.

Contacting St. Luke's Hospital: St. Luke's Hospital Privacy Officer can be reached by phone, fax, e-mail or mail.

Phone: **314.205.6544 – Press 2**
Fax: **314.205-6517**
E-Mail: **slhprivacyofficer@stlukes-stl.com**

Mailing Address:
St. Luke's Hospital Privacy Officer
P.O. Box 6668
Chesterfield, Missouri 63006

You can request a paper copy of this notice by contacting St. Luke's Privacy Officer or from the area where you received your services.

Effective: Apr 2003
Revised: Oct 2011; Sept 2013; Aug 2016

St. Luke's HOSPITAL

*** In order for us to serve you better please PRINT clearly and complete all blanks BEFORE your arrival. ****

Patient Information

Social Security Number	Legal Last Name	Legal First Name	MI	Nick Name
- -				

Address	City	State	Zip

Home Phone	Cell Phone	Date of Birth	Age	Sex
( ) -	( ) -	/ /		☐ F ☐ M

Marital Status
☐ (**M**)arried ☐ (**S**)ingle ☐ (**D**)ivorced ☐ (**W**)idowed ☐ (**L**)ife Ptnr

E-mail Address

Ethnicity:

Language:_____ ☐ **Hispanic/Latino** ☐ **Non-Hispanic/Latino** **Race:**_____

Spouse/Emergency Contact/Parent if Minor

Spouse's Full Legal Name or (Insured Parent if Minor) ☐ Spouse ☐ Parent ☐ Student ☐ Other	Social Security #	Date of Birth
	- -	/ /

Emergency Contact / Relationship	Phone Number	Address
1-		
2-		

Please give us your REFERRING PHYSICIAN information.
Please provide correct spelling of first and last name, along with phone number.

If your physicians are located at St. Luke's Hospital we do not need address and phone number.

Referring Physician ***Last Name*** _____ ***First Name***_____ **Phone** (____)_____

Internist ***Last Name*** _____ ***First Name***_____ **Phone** (____)_____

Gynecologist ***Last Name***_____***First Name***_____ **Phone (____)**_____

PHARMACY NAME: _____**Telephone Number:**__**(_____)**_____

PHARMACY ADDRESS:_____

Employer Information

Occupation	Phone	

Address	City	Zip

Employer Spouse

Occupation	Date of Birth	Social Security

Address	City	Zip

I, the patient or guarantor, certify that the information on this form is true and the best of my knowledge, and that a photocopy of this document is to be considered as valid as an original. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I agree that any health service provided to me by the physician/St. Luke's Medical Group that is NOT authorized by the appropriate referral/authorization form or number from my PCP is my responsibility. I authorize physician/ St. Luke's Medical Group to render medical treatment (and any diagnostic procedure preformed), and to release information to process insurance claims and determine Medicare benefits. I also authorize my insurance claim and or authorized Medicare benefits to be paid directly to the physician/ St. Luke's Medical Group. I understand that a 35% collection fee will apply to all patient balances that must be turned over to our collection agency. I authorize St. Luke's Medical Group to obtain any reports, slides, films and test results that are relevant to my treatment at St. Luke's Medical Group from any other facilities where I have obtained medical care.

X_____ _____

PATIENT SIGNATURE OR RESPONSIBILE PARTY IF MINOR ***DATE***

PRF1001

OUTPATIENT PRIVACY RIGHTS AND RELEASE FORM

St. Luke's HOSPITAL
Our specialty is you.

ACKNOWLEDGEMENT

1. **PATIENT RIGHTS:** A copy of my Patient Rights has been made available to me.

2. **NOTICE OF PRIVACY PRACTICES:** A copy of St. Luke's Hospital Notice of Privacy Practices has been made available to me.

   ☐ Patient unwilling or unable to sign acknowledgement.

   Reason: _____

3. May we leave information regarding appointment changes or reminders on answering machine or voice mail?

   Home Phone: _____ May we leave a message? Y N
   Cell Phone: _____ May we leave a message? Y N
   Work Phone _____ May we leave a message? Y N

4. Email address: _____ ☐ Do not have or do not wish to share

RELEASE OF INFORMATION

In order to protect your privacy and maintain confidentiality, we require your consent to release medical information. Please list all individuals that we may share information with regarding your medical condition and care.

Name	Relationship (spouse, friend, etct)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

_____ _____
Signature of patient (or Legal Guardian/Representative) *Date/Time*

_____
Relationship to Patient

Employee Signature: _____ Date: _____ Time: _____

ROI1001

Return completed form to:
St. Luke's Hospital Health Information Services
FAX: (314) 205-6106

Patient Name: _____ Treatment Date: _____
Please print

Date of Birth: _____ Phone: _____

Purpose of Request: Personal Use

I hereby authorize: Department of Oncology and Hematology

To Release Record To:	To Obtain Record From:
SELF	
Street Address:	Organization: St. Luke's Hospital
City, State, Zip:	Address:

I specifically authorize the use and disclosure of the following:

☐ **Clinical Abstract**
includes all documents listed →

OR

☐ Discharge Summary
☐ History & Physical
☐ Consultation Reports
☐ Operative Reports
☐ ER Physician Note
☐ Laboratory Reports
☐ Radiology Reports
☐ Cardiology Reports

☐ Other (please specify): _____

☐ Complete Record (entire medical record including nursing notes and orders)

The information to be used or disclosed pursuant to this authorization may include information relating to: (1) AIDS or HIV infection; (2) treatment of drug or alcohol use; or (3) mental or behavioral health or psychiatric care; (4) sexually transmitted disease; or (5) genetic testing.

Except: _____

I may revoke this authorization in writing at any time. I understand that such revocation will not have any effect on the information already used or disclosed before receipt of my written notice of revocation. Unless earlier revoked, this authorization will expire one year from the date it was signed. I understand I may choose to restrict or extend the expiration date. I may request to inspect or copy the information to be disclosed. I may refuse to sign this authorization. I understand that I am not required to sign the authorization to receive treatment. Once release of this information is made to the above named person/organization, my information may be subject to re-disclosure by the recipient.

I may be charged fees for the copying of such information if I am requesting information for myself or for a third party. Such fees will comply with state and federal laws.

I have read the above information and authorize disclosure of the identified information to the person/organization and for the purpose described herein. I understand that, by signing this document, I release and discharge the disclosing entity from any liability and will hold it harmless for any release made pursuant to the authorization.

_____ _____ _____
Signature of Patient/Legal Guardian/Personal Representative | Date | Time

_____ _____ _____
If someone signs on behalf of the patient, state your relationship to the patient | Date | Time

Authorization Expires: 1 YEAR
(up to one year if not otherwise specified)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

St. Luke's Hospital
232 So. Woods Mill Rd Chesterfield, MO 63017

St. Luke's HOSPITAL

e-Prescribing Consent

ePrescribing is defined as a Physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that that ability to electronically send prescriptions is an important element in improving the quality of Patient care. ePrescribing greatly reduces medication errors and enhances Patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe Program. These include:

☑ Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.

☑ Medication history transactions – Provides the physician with information about medications the Patient is already taking to minimize the number of adverse drug events.

☑ Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the Patient's prescription has been picked up, not picked up, or partially filled.

By signing this *Consent Form*, you are agreeing that St. Luke's Medical Group can request and use your prescription medication history from other healthcare Providers and/or third party pharmacy benefit Payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to St. Luke's Medical Group to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name Patient DOB

_____ _____
Signature of Patient or Guardian Date

Relationship to Patient _____

Pharmacy Name _____ Pharmacy Number _____

Albert L. Van Amburg, M.D.
Donald F. Busiek, M.D.
Elliot E. Abbey, M.D.

David Kuperman, M.D.
Jill Oberle, M.D.
Melissa Rooney, M.D.

MEDICAL HISTORY

Name: _____ Birthdate: _____

Family History: PLEASE NOTE IF ALIVE OR DECEASED. LIST CAUSE OF DEATH OR ANY SIGNIFICANT ILLNESSES.

☐	Mother:	_____	Alive:	Y	N	Age: _____
☐	Father:	_____	Alive:	Y	N	Age: _____
☐	Sister:	_____	Alive:	Y	N	Age: _____
☐	Brother:	_____	Alive:	Y	N	Age: _____
☐	Children:	_____	Alive:	Y	N	Age: _____

Past and Current Medical History/Illness & Transfusions:

_____
_____
_____
_____

Past Surgeries/Dates:

_____
_____
_____

Primary Care Physician: _____

Other Physicians:

_____ _____

_____ _____

Medications: (NAME, DOSAGE, HOW OFTEN)

_____
_____
_____

Drug Allergies/Reactions:

_____
_____
_____

Alcohol & Drug History: Alcohol _____ x per week/month
Drug _____ x per week/month

Smoking: How long? _____ How much? _____ Date Stopped: _____
Support Person or Family Contact: _____ Relationship: _____
Pharmacy Name: _____ Phone: _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

NAME_____

Influenza Immunization

Have you had the influenza vaccine? yes ☐ no ☐

Pneumococcal vaccine only? yes ☐ no ☐

Tobacco Use Screening

Smoking Status: Never Current (Circle One)

How Long:_____

How Much (Packs Per Day_____

Date Stopped Smoking:_____

Alcohol Use

Do you drink yes ☐ no ☐

Currently uses alcohol yes ☐ no ☐

Amount per week_____

Date Stopped Drinking:_____

Alcohol Use

Recreational drug use yes ☐ no ☐

Drug used and dates_____

Environmental/Functional

Living Situation:_____

Blind or Deaf (circle one)

Glasses: yes ☐ no ☐

Contacts: yes ☐ no ☐

Hearing aids: yes ☐ no ☐

Devices Needed: Cane Walker Wheelchair (Circle One)

Decline in Function Last 3 Mos: yes ☐ no ☐

Language

Language Preference if not English_____

Family-Social History

Occupation:_____

Number of Children:_____

Family History of Cancer

(List any family member with cancer and type)

_____

_____

_____

_____

_____

Domestic Concerns

Any domestic concerns yes ☐ no ☐

Emotional support available yes ☐ no ☐

Coping yes ☐ no ☐

Previous Cancer Treatment

Body Area Treated:_____

Prior Chemo Date/Location:_____

Chemo Physician of Record:_____

Prior RT Date/Location:_____

RT Physician of Record:_____

Surgical History Continued

Surgery 6 and Date:_____

Surgery 7 and Date:_____

Surgery 8 and Date:_____

Surgery 9 and Date:_____

Past Medical History

Please list any past medical problems you have or have had in the past:

Past Medical History 1::_____

Past Medical History 2::_____

Past Medical History 3::_____

Past Medical History 4::_____

Past Medical History 5::_____

Past Medical History 6::_____

Past Medical History 7::_____

Past Medical History 8::_____

Past Medical History 9::_____

Past Medical History 10::_____

Past Medical History 11::_____

Past Medical History 12::_____

Past Medical History 13::_____

Past Medical History 14::_____

Surgical History

Please list any past surgeries you have

Surgery 1 and Date:_____

Surgery 2 and Date:_____

Surgery 3 and Date:_____

Surgery 4 and Date:_____

Surgery 5 and Date:_____

Review of Systems

Sleep Disturbance

	yes	no
History of Sleep Apnea:	☐	☐
Use CPAP:	☐	☐

Immunologic

	yes	no
Rheumatoid Arthritis:	☐	☐
Lupus:	☐	☐
Scleroderma:	☐	☐
Crohn's Disease:	☐	☐
Ulcerative Colitis:	☐	☐
Multiple Sclerosis:	☐	☐
Immune Deficiency::	☐	☐

General

	yes	no
Fatigue:	☐	☐
Fever:	☐	☐
AIDS:	☐	☐
HIV:	☐	☐
Chills:	☐	☐
Night Sweats:	☐	☐
History of MRSA:	☐	☐
History of VRE:	☐	☐
History of C-Diff:	☐	☐

Ocular/Visual

	yes	no
Glaucoma::	☐	☐
Macular Degeneration:	☐	☐
Cataracts::	☐	☐
Redness:	☐	☐
Blurred vision:	☐	☐
Change in Vision:	☐	☐
Eye Pain:	☐	☐

Breathing/Respiratory

	yes	no
Wheezing:	☐	☐
Asthma:	☐	☐
Emphysema:	☐	☐
COPD:	☐	☐
Tuberculosis:	☐	☐
Pneumonia:	☐	☐
Pleurisy:	☐	☐
Chronic Bronchitis:	☐	☐
Sputum:Color Amount:	☐	☐
Tracheostomy:	☐	☐
Shortness of Breath:	☐	☐
Home O2 Use/CPAP: (circle one)	☐	☐

O2-Liters Per Minute:_____

ENT and Mouth

	yes	no
Change in Hearing:	☐	☐
Ringing in Ears:	☐	☐
Nose Bleeds:	☐	☐
Sinus Problems:	☐	☐

ENT and Mouth Continued

	yes	no
Gums Bleeding:	☐	☐
Sore throat:	☐	☐
Hoarseness:	☐	☐
Sore tongue:	☐	☐
Mouth Sores:	☐	☐
Vertigo/Dizziness:	☐	☐

Cardiovascular

	yes	no
Chest Pain:	☐	☐
Palpitations:	☐	☐
Swelling of Extremities:	☐	☐
Blood Clots, History of::	☐	☐
History of Heart Attack	☐	☐
Heart Murmur:	☐	☐
Irregular Heart beat (AFIB)	☐	☐
Mitral Valve Prolapse:	☐	☐
Congestive Heart Failure:	☐	☐
Leg Cramps:	☐	☐
Rheumatic Fever:	☐	☐
Hypertension:	☐	☐
High Cholesterol:	☐	☐
Aortic Aneurysm:	☐	☐

Gastrointestinal

	yes	no
Heartburn/Indigestion:	☐	☐
Reflux:	☐	☐
Ulcer:	☐	☐
Abdominal pain/cramps:	☐	☐

Gastrointestinal Continued

	yes	no
Nausea:	☐	☐
Vomiting:	☐	☐
Blood in Vomit:	☐	☐
Diarrhea:	☐	☐
Constipation:	☐	☐
Bloody Stools:	☐	☐
Black Stools:	☐	☐
Jaundice:	☐	☐
Hepatitis:	☐	☐
Irritable bowel Syndrome:	☐	☐
Colostomy:	☐	☐
Ileostomy:	☐	☐
Rectal bleeding:	☐	☐
Hemmorrhoids:	☐	☐

Last Colonoscopy: (date)_____

	yes	no
Feeding Tube	☐	☐

Endocrine

Diabetes # of years:_____

	yes	no
Are you using Insulin	☐	☐
Thyroid Disease:	☐	☐
Hypo:	☐	☐
Hyper:	☐	☐
Thyroid Cancer:	☐	☐

Genitourinary

	yes	no
Incontinence:	☐	☐
Frequent Urination:	☐	☐
Frequent Urinary Infections:	☐	☐

Genitourinary Continued

	yes	no
Continent Diversion:	☐	☐
Peritoneal Dialysis:	☐	☐
Hemodialysis:	☐	☐
Chronic Kidney Disease:	☐	☐
Kidney Stones:	☐	☐
Blood in Urine:	☐	☐
Painful Urination:	☐	☐
Difficulty Starting Stream:	☐	☐
Scrotal Mass:	☐	☐

Reproductive

	yes	no
Could you be pregnant:	☐	☐

Due date:_____

Age at 1st Period:_____

Last Menstrual Period:_____

Age at Menopause:_____

	yes	no
Hot Flashes/Flushes:	☐	☐

Number of Pregnancies:_____

Number of Live Births::_____

Age at first live birth:_____

Number breast fed/how long::_____

Birth control pill # of years:_____

Birth control age stopped:_____

Number of Years on Hormones::_____

Name of Hormone::_____

Mammogram History

Mammogram most recent date:_____

Location Mammogram done::_____

	yes	no
Breast Self Exams Done::	☐	☐

Previous Mammogram Date:_____

	yes	no
Breast Tenderness/Masses:	☐	☐

Breast Biopsy side and date:_____

Breast Biopsy Result::_____

Gynecological

Last GYN exam::_____

Last PAP Smear:_____

	yes	no
Abnormal Vaginal Bleeding:	☐	☐
Abdominal/Pelvic Pain:	☐	☐

Skin

	yes	no
Eczema:	☐	☐
Changes in Pigmentation:	☐	☐
Bruises/Abrasions:	☐	☐
Lumps:	☐	☐
Rashes:	☐	☐
Change in Mole:	☐	☐
Non-Healing Wound:	☐	☐
Itching:	☐	☐
Hair Loss:	☐	☐
Change in Nails:	☐	☐

Skin Cancer/Type/Location::_____

Musculoskeletal

	yes	no
Joint swelling/tenderness:	☐	☐
Muscle Pain/Weakness:	☐	☐
Osteoarthritis:	☐	☐
Gout:	☐	☐
Fibromyalgia:	☐	☐
Osteopenia:	☐	☐
Osteoporosis:	☐	☐
Back Pain:	☐	☐

Back Injury (specified):_____

Last Bone Density Scan(date)_____

Neurological

	yes	no
Headaches/Migraines:	☐	☐
Dizziness:	☐	☐
Fainting:	☐	☐
Stroke:	☐	☐
Brain Aneurysm:	☐	☐
Difficulty with Speech:	☐	☐
Numbness/Tingling:	☐	☐
Memory loss:	☐	☐
Dementia:	☐	☐
Alzheimer's Disease:	☐	☐
Weakness:	☐	☐
Paralysis:	☐	☐
Change in Gait or Balance:	☐	☐
Tremors:	☐	☐
Peripheral Neuropathy:	☐	☐
Seizure:	☐	☐

Last Seizure:_____

Psychiatric Emotional

	yes	no
Change in Memory:	☐	☐
Panic Attacks:	☐	☐
Claustrophobia:	☐	☐
Bipolar:	☐	☐
Depression:	☐	☐
Anxiety:	☐	☐

Hematological

	yes	no
Anemia:	☐	☐
Unusual bleeding:	☐	☐
Easy Bruising:	☐	☐
Frequent Bleeding:	☐	☐
Swollen Glands:	☐	☐

BREAST CENTER ONLY

Breast Oncologic History

	yes	no
Family Hx of Breast Cancer:	☐	☐

Maternal Relative

	yes	no
Mother:	☐	☐
Mother Before Menopause:	☐	☐
Mother Age at diagnosis::	☐	☐
Maternal Grandmother:	☐	☐
Maternal G-M before Menopause:	☐	☐

Maternal g-mother age at diag::_____

	yes	no
Sister:	☐	☐
Sister before Menopause:	☐	☐

Sister Age at diagnosis::_____

BREAST CENTER ONLY CONTINUED

	yes	no
Maternal Aunt:	☐	☐
Maternal Aunt before Menopause:	☐	☐

Maternal Aunt Age at diagnosis:_____

	yes	no
Other Maternal Relative::	☐	☐

Paternal Relative

	yes	no
Paternal Grandmother:	☐	☐
Paternal G-M before Menopause:	☐	☐

Paternal G-mother age at dx:_____

	yes	no
Paternal Aunt:	☐	☐
Paternal Aunt before Menopause:	☐	☐

Paternal Aunt age at diagnosis:_____

	yes	no
Other Paternal Relative::	☐	☐
Family Hx Males w/ Brst Cancer:	☐	☐
Family w/history ovarian cancr:	☐	☐
Ashkenazi Jewish heritage:	☐	☐

BREAST PATIENT ONLY

Tamoxifen Start Date::_____

Tamoxifen End Date::_____

Aromatase Inhibitor start date:_____

Aromatase Inhibitor end date::_____