NORTON OCCUPATIONAL MEDICINE

Norton Occupational Medicine 12903 Shelbyville Road Louisville KY 40203	Norton Occupational Medicine 438 Shepherdsville Pkwy #2 Shepherdsville KY 40165	Norton Occupational Medicine 3605 Northgate Court #110 New Albany IN 47150

CONSENT FOR SERVICES

Date: _____

Name: _____ **Social Security #**_____
First M.I. Last

Address: _____ **SEX**: Male Female

City _____ **State**_____ **Zip Code**_____

Home Phone: (**)** _____ **Cell: (** **)** _____

Work Phone: (**)** _____

Date of Birth: _____ **Age**:_____ **Email Address**: _____

Employer Name: _____ **Employer Phone**: ( )_____

Employer Contact _____ **Employer Address**: _____

City:_____ **State**:_____ **Zip Code**: _____

Optional: Injuries Only

Date and Time of Injury: _____ Injury Description: _____

VOLUNTARY CONSENT FOR SERVICES AND RELEASE OF INFORMATION

I voluntarily consent to care that may involve routine diagnostic tests, procedures, and/or medical treatment as prescribed by my physician and/or advance practice registered nurse and performed by employees of Norton Occupational Medicine. No guarantee has been given by anyone as to the results of the care to be provided. I also consent and agree to provide breath, blood, hair and/or urine sample(s) for the purposes of testing for the presence of alcohol and/or drugs. I authorize these samples to be sent out to the laboratory for analysis if needed.

I understand and acknowledge that I may require the services of physicians or other health care providers who are not employees of Norton Occupational Medicine, including, but not limited to, radiologists. I agree that Norton Healthcare is not responsible for and does not assume any liability for the activities of any such physicians or practitioners who are not its employees.

I authorize any treating physician/nurse practitioner and/or Norton Occupational Medicine to disclose to my employer, potential employer, or insurance carrier, as appropriate, any information regarding this treatment and/or related tests and services. I understand that any refusal to submit for testing, or refusal of certain tests, may subject me to adverse consequences with the requesting party and/or any applicable government agencies. I acknowledge that a copy of the Privacy Practices has been made available to me.

Date: _____ **Time**: _____

PATIENT SIGNATURE (***or*** *check below*) _____

( ) Parent ( ) Guardian ( ) Legally Authorized Representative

Witness: _____

Patient unable to consent because _____

( ) Interpreter services used during informed consent discussion - Interpreter Name and ID # _____

Norton Healthcare Telemedicine Informed Consent

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Norton Healthcare providing health care services to me via telemedicine. The information discussed may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconferencing technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures have been implemented to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telehealth encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems may delay medical evaluation and treatment for your encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telemedicine visit and schedule a face-to-face visit.

4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I hereby authorize Norton Healthcare to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or Authorized Person) _____ Date _____

If Authorized Signer, relationship to patient _____

Witness _____ Date _____

NORTON
OCCUPATIONAL MEDICINE

EXAMINATION HISTORY

I. IDENTIFICATION:

Name:_____Social Security #: _____-_____-_____

Address:_____

Sex: ☐ Female ☐ Male Date of Birth: _____/_____/_____ Age:_____

Home phone number:_____ Work Phone Number:_____

Personal Physician:_____

Job position:_____

Type of examination: ☐ Pre-placement ☐ Periodic ☐ Return to Work ☐ DOT ☐ Other:_____

II. OCCUPATIONAL PROFILES:

Fill in the table below listing all jobs in the past 5 y ears which you have worked including short-term or part-time employment. Start with your present job and go back to the first.

Work place (employer name, address):	Dates worked (Approx. begin date/end date):	Did you work full time?	Type of industry (describe):	Describe your job dutes:	Know health hazards in the work place?	Protective equipment used?	Were you ever off work for a health problem or injury?

III. EXPOSURE HISTORY

Please describe any health problems or injuries you have experienced connected with your present or past jobs.

1. Have any of your co-workers experienced health problems or injuries connected with the same job? If yes, please describe: ☐Yes ☐No

   _____

2. Do you smoke cigarettes, cigars, or pipes? ☐Yes ☐No
   If so, which and how many per day?_____
   If you have quit, when?_____
3. Did you ever smoke? ☐Yes ☐No
   If so, how much and for how long?_____
4. Do you have any allergies or allergic conditions? ☐Yes ☐No
   If so, please describe:_____
5. Have you ever worked with any substance that cause you to break out in a rash? ☐Yes ☐No
   If so, please describe your reaction and the name of the substance that caused it:

   _____
6. Have you ever been off work for more than a day because of any illness or injury related to work? ☐Yes ☐No
   If so, please describe:_____
7. Have you ever worked at a job which caused you trouble breathing, such as a cough, shortness of breath, or wheezing? ☐Yes ☐No
   If so, please describe:_____
8. Have you ever changed jobs or worked assignments because of health problems or Injuries? ☐Yes ☐No
   If so, please describe:_____
9. Do you frequently experience pain in your lower back or have you been under a doctor's care for back problems? ☐Yes ☐No
   If so, please describe:_____

IV. PERSONAL MEDICAL HISTORY

1. Please list all medical illnesses which you have now or have had in the past:

   _____

   _____

2. Please list all operations you have had in the past and approximate dates:

   _____

   _____

3. Please list any serious injuries you have had in the past and approximate dates:

   _____

   _____

4. Please list any medications, both prescribed and over-the-counter, which you now use regularly or occasionally:

   _____

   _____

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
RECORD OF ADULT PHYSICAL HEALTH EXAMINATION

State Form 45877 (R3 / 10-02) / BCD 0054

CHILDCARE HEALTH SECTION
BUREAU OF CHILD DEVELOPMENT
DIVISION OF FAMILY AND CHILDREN

Name	Date of birth
Address (*number and street, city, state, ZIP code*)	

MEDICAL HISTORY

I. List past hospitalizations / operations / accidents:

II. Communicable diseases you have had:

☐ Measles	Month / year	☐ Scarlet Fever	Month / year	☐ Rubella (German Measles)	Month / year
☐ Chicken Pox	Month / year	☐ Mumps	Month / year	☐ Whooping Cough	Month / year
☐ Other:					Month / year

III. Conditions (*Please explain if present*):

Allergies:

Chronic health conditions:

Use of any drugs / medication:

Why?

PHYSICAL EXAMINATION

I. Mantoux TB skin test *	Date	Result (*in mm*)
Chest X-ray, if above skin test is positive?	Date	Result

Other laboratory test as ordered by physician:

II. Does this person have any health condition that would be hazardous to the person or to the children in a group setting as a result of participation in normal activities (*including sports*)?

☐ No ☐ Yes

If Yes, what modifications of normal activities are necessary?

III. Have you prescribed any medications and / or special routines (*such as diet*) which should be included in planning this person's activities?

☐ No ☐ Yes

Explain:

Date of exam	Signature of physician

* Annual testing for tuberculosis is required.