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 _____

Protected Health Information (PHI)

MEDICAL & HEALTH HISTORY FORM

Date _____

Time In _____ _____ Time Out

Name: **Date of Birth:** ____/____/____ **Sex:** **M** **F**

I. HAVE YOU EVER HAD?			
1. Injury, illness, or hospitalization in past 5 years	○ Yes ○ No	12. Head/brain injury, illness, or disorder	○ Yes ○ No
2. High blood pressure	○ Yes ○ No	13. Stroke, paralysis, or loss of consciousness	○ Yes ○ No
3. Diabetes (controlled by diet or medication)	○ Yes ○ No	14. Anemia (low blood count)	○ Yes ○ No
4. Heart disease, heart attack, or heart surgery	○ Yes ○ No	15. Cancer	○ Yes ○ No
5. Lung disease, asthma, or emphysema	○ Yes ○ No	16. Prostate or urinary tract problems	○ Yes ○ No
6. Liver disease	○ Yes ○ No	17. Stomach ulcers or reflux disease	○ Yes ○ No
7. Seizures or epilepsy	○ Yes ○ No	18. Disorder of hearing or balance	○ Yes ○ No
8. Nervous or psychiatric disorder (anxiety, depression)	○ Yes ○ No	19. Injury/disorder of your neck or back	○ Yes ○ No
9. Sleep apnea or other sleep disorder	○ Yes ○ No	20. Injury/disorder of your joints or extremities	○ Yes ○ No
10. Kidney disease, dialysis	○ Yes ○ No	21. Chronic pain of any kind	○ Yes ○ No
11. Regular, frequent alcohol or habit-forming drug use	○ Yes ○ No	22. Other surgery, hospitalization, or medical problem	○ Yes ○ No
II. HAVE YOU RECENTLY OR ARE YOU CURRENTLY EXPERIENCING?			
23. Fever or chills	○ Yes ○ No	29. Changes in your skin, nails, or hair	○ Yes ○ No
24. Changes in vision	○ Yes ○ No	30. Frequent or severe headaches	○ Yes ○ No
25. Sinus pain, drainage, congestion	○ Yes ○ No	31. Night sweats	○ Yes ○ No
26. Chest pain	○ Yes ○ No	32. Unintentional/unexplained weight loss	○ Yes ○ No
27. Shortness of breath	○ Yes ○ No	33. Increased stress, anxiety, or mood swings	○ Yes ○ No
28. Changes in bowel or bladder habits	○ Yes ○ No	34. Joint swelling or pain	○ Yes ○ No

III. HAVE YOU EVER?	
35. Been rejected for employment for health reasons?	○ Yes ○ No
36. Been discharged or rejected for military service?	○ Yes ○ No
37. Applied for or received disability compensation?	○ Yes ○ No
38. Had exposure to poisons, asbestos, or other hazardous materials?	○ Yes ○ No
39. Had a prior occupational illness or injury?	○ Yes ○ No
40. Females only: Are you pregnant?	○ Yes ○ No
41. Females only: Any other gynecological/obstetric problems?	○ Yes ○ No
42. Are you allergic to any medications or dye? (*If yes, list below.*)	○ Yes ○ No

Please list all of your current medications, vitamins, and herbal supplements, including over-the-counter medications:

_____

_____

_____

_____

_____

For any yes answer, please respond with corresponding #, diagnosis, and current limitations.

Are there any diseases that run in your family? ○ Yes ○ No Explain:

When was your last tetanus shot?

Do you smoke? ○ Yes ○ No If "Yes", how much? Do you drink alcohol? ○ Yes ○ No If "Yes", how much?

PHYSICIAN'S NOTES

Signature of employee:	**Signature of medical examiner:**

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Patient Name: _____ Date of Birth: _____

POSITIVE TB REACTOR QUESTIONNAIRE

HAVE YOU EVER:

1.	Had swelling from TB skin test?	YES	NO
2.	Been told not to have a TB skin test?	YES	NO
3.	Had TB?	YES	NO
4.	Been treated for TB?	YES	NO
5.	Had a BCG injection?	YES	NO
6.	Tested positive for HIV or other immune deficiency?	YES	NO
7.	Had a transplant, Head/Neck or Lung Cancer, Leukemia, Lymphoma, Diabetes, Silicosis, Chronic Renal Failure, High Dose Steroid Use, Alcoholism or Drug Use?	YES	NO
8.	Had prior contact with a person who had active TB?	YES	NO
9.	Worked in a jail, prison, nursing home, hospital, shelter for the homeless, alcoholics, or drug users?	YES	NO
10.	Coughed up blood?	YES	NO
11.	Had a persistent cough?	YES	NO
12.	Had unplanned weight loss?	YES	NO
13.	Had night sweats?	YES	NO
14.	Had extreme fatigue?	YES	NO

_____ **MD / NP**

Provider Signature