NORTHSIDE HOSPITAL

Full Name:_____ Date of Birth _____
(First) (Middle) (Last)

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____

*Email_____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Other ☐ Unknown/Declined

Preferred Language ☐ English ☐ Spanish ☐ Chinese(Cantonese) ☐ Chinese(Mandarin) ☐ French ☐ German
☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer _____ Employer Phone_____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

If this practice lacks the capability for text or email reminders, may we use the phone number for reminders ☐ yes ☐ no.

Pharmacy Information

Pharmacy Name _____ Phone_____ Fax_____

Pharmacy Address _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name _____ Date of Birth _____Relationship to Patient_____

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____ *Email _____

***Note:** *By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.*

Emergency Contacts Information and Relationship to Patient:

Name _____Relationship _____Phone_____

Name _____Relationship _____Phone_____

Referring Physician Information:

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Does your insurance require a referral? ____YES ____NO; **if yes,** please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance	_____	_____
Name of Policy Holder	_____	_____
Date of Birth of Policy Holder	_____	_____
Policy/Member ID Number	_____	_____
Group/Plan Number	_____	_____
Phone Number	_____	_____
Effective Date of Policy	_____	_____

Patient/Guarantor Signature _____ **Date** _____

Reorder #26985 PP0001 (GCR)
Piedmont Graphics 02/19/16

PATIENT REGISTRATION FORM

NORTHSIDE HOSPITAL

PHYSICIAN PRACTICE

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

English - Spanish

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, in consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, you may receive a bill for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent annually. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.

_____ I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice is subject to change. If Northside Hospital changes the Notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

Reorder #26703 PP0004 (GCR)
Piedmont Graphics Rev. 05/27/16

ANNUAL ACKNOWLEDGEMENT

NORTHSIDE HOSPITAL

English - Spanish

PATIENT'S NAME: _____ DATE OF BIRTH:_____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at a Northside Hospital affiliated medical practice ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals. The Minor Procedures are performed by a physician or qualified mid-level provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to the Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Consent To Download Prescription Records. The Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

Medications From Outside Source. I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice; The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

_____ _____
Witness Date Time Signature of Patient or Legal representative Date Time

_____ _____
Interpreter (Note: if phone interpretation used, record interpreter ID#) Relationship to patient reason patient can't sign

Reorder #26702 PP0042 (GCR)
Piedmont Graphics 02/20/16

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

NORTHSIDE HOSPITAL

Newtown Medical Associates

Patient's name: _____ **Date of Birth:** _____

Medicare B enrollment date: _____ *

Today's date: _____

Health Risk Assessment has been reviewed by physicians, signed and dated: Initial_____

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury/Illness/Surgery	Date	Hospitalized? (Indicate Yes or No)

Medications, supplements and vitamins:

Drug allergies/other allergies:

Social history notes (including diet, physical activities, alcohol use, drug use and tobacco use):

Family history notes:

	Mother	Father	Brother	Sister	Son	Daughter
Deceased						
Hypertension						
Stroke						
Diabetes						
Kidney disease						
Heart disease						
Cancer						

Other physicians and providers/suppliers of care (include provide name, specialty & type of care)

MEDICARE WELLNESS VISIT
ANNUAL WELLNESS VISIT

DEPRESSION SCREEN*

1. Over the past 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No
2. Over the past 2 weeks, have you felt little interest/pleasure in doing things? ☐ Yes ☐ No

FUNCTIONAL ABILITY/SAFETY SCREEN*

1. Was the patient's timed Up & Go test unsteady or long than 30 seconds? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? ☐ Yes ☐ No
4. Have you noticed any hearing difficulties? ☐ Yes ☐ No

*A "yes" answer to any of the questions regarding depression or function/safety should trigger further evaluation, screenings or referrals. (Use additional screening questionnaires)

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ BMI:_____

Visual Acuity: Left _____ R _____

EVALUATION OF COGNITIVE FUNCTION

Mood/Affect: _____

Appearance: _____

Family member/Caregiver input: _____

ELECTROCARDIOGRAM (G0403-EKG) – Only at the time of the IPPE

Referral or result:_____

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING:

DISCUSSION OF ADVANCE DIRECTIVE (PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT-if patient consents):

☐ **List of Community Resources was given to patient**

Physicians signature: _____ **Date:**_____

MEDICARE WELLNESS VISIT
ANNUAL WELLNESS VISIT

NORTHSIDE HOSPITAL

Newtown Medical Associates

(must be viewed by physician, signed and dated)

Annual Wellness Visit: ___ Initial ___ Subsequent

Patient's name: _____ **Date of Birth:** _____

Medicare B eligibility date: _____ **Today's date:** _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age? ☐ 65-69 ☐ 70-79 ☐ 80 or older
2. Are you a female or male? ☐ Male ☐ Female
3. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely

4. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely

5. During the past four weeks, how much bodily pain have you generally had?

   ☐ No pain
   ☐ Very mild pain
   ☐ Mild pain
   ☐ Moderate pain
   ☐ Severe pain

6. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

   ☐ Yes, as much as I wanted
   ☐ Yes, quite a bit
   ☐ Yes, some
   ☐ Yes, a little
   ☐ No, not at all

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

   ☐ Very heavy
   ☐ Heavy
   ☐ Moderate
   ☐ Light
   ☐ Very light

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ☐ Yes ☐ No

9. Can you go shopping for groceries or clothes without someone's help? ☐ Yes ☐ No

10. Can you prepare your own meals? ☐ Yes ☐ No

11. Can you do your housework without help? ☐ Yes ☐ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around in the house? ☐ Yes ☐ No

13. Can you handle your own money without help? ☐ Yes ☐ No

14. During the past four weeks, how would you rate your health in general?

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

15. How have things been going for you during the past four weeks?

☐ Very well, could hardly be better
☐ Pretty well
☐ Good and bad parts, about equal
☐ Pretty bad
☐ Very bad; could hardly be worse

16. Are you having difficulties driving your car?

☐ Yes, often
☐ Sometimes
☐ No
☐ Not applicable, I do not use a car

17. Do you always fasten your seat belt when you are in a car?

☐ Yes, usually
☐ Yes, sometimes
☐ No

18. How often during the past four weeks have you been *bothered* by any of the following problems?

Please indicate with: Never, Seldom, Sometimes, Often or Always

Falling or *dizzy* when standing up_____
Sexual problems _____
Trouble eating well _____
Teeth or denture problems_____
Problems using the telephone _____
Tiredness or fatigue_____

19. Have you fallen two or more times in the past year? ☐ Yes ☐ No

20. Are you afraid of falling? ☐ Yes ☐ No

21. Are you a smoker?

☐ No
☐ Yes, and I might quit
☐ Yes, but I'm not ready to quit

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ 10 or more drinks per week
☐ 6-9 drinks per week
☐ 2-5 drinks per week
☐ One drink or less per week
☐ No alcohol at all

23. Do you exercise for about 20 minutes three or more days a week?

☐ Yes, most of the time
☐ Yes, some of the time
☐ No, I usually do not exercise this much

24 Have you been given any information to help you with the following:

Hazards in your house that might hurt you? ☐ Yes ☐ No
Keeping track of your medications? ☐ Yes ☐ No

25. How often do you have trouble taking medicines the way you have been told to take them?

☐ I do not have to take medicine ☐ Sometimes I take them as prescribed
☐ I always take them as prescribed ☐ I seldom take them as prescribed

26. How confident are you that you can control and manage most of your health problems?

☐ Very confident ☐ Not very confident
☐ Somewhat confident ☐ I do not have any health problems

27. What is your race? (Check all that apply)

☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ Hispanic or Latino origin or descent
☐ Other _____

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Provider signature: _____ Date: _____

NORTHSIDE HOSPITAL

Newtown Medical Associates

Patient Name _____

Date of birth _____ /_____ /_____
Month Day Year

A Medicare Annual Wellness Exam will include the following:

1) Review / Update of medical history
2) Review / Update of family history
3) Evaluation for health screening tests based on risk factors, age, and family history
4) Personalized Prevention plan to keep you healthy

The visit does not include a hands-on exam, any testing that the doctor may recommend, discussion about any new or current medical problems, conditions or medication. If you require or request services beyond those listed above, this could include the evaluation of a new or chronic symptom / medical issue or the management of an illness, we may schedule another visit to address those issues or an appropriate office visit code will be billed along with your annual examination to your insurance company as well.

If you are uncertain of your insurance coverage for the Medicare Annual Wellness Exam, you may wish to contact your insurance company.

I understand if an additional fee will be charged to my insurance, I am responsible for applicable copays, coinsurance or deductible.

_____ _____
Print Name of Patient Date

_____
Patient Signature

MEDICARE PATIENTS

NORTHSIDE HOSPITAL

Newtown Medical Associates

Create two copies of this page: One for the chart and one to give to the patient.

Patient's name: _____ **Date of Birth:** _____

Today's date: _____

Service	**Recommendation**
Vaccinations	**Date or N/A**
Influenza (every 12 months)	
Pneumococcal (once in a lifetime)	
Hepatitis B	
Labs	**Date or N/A**
PSA-males (every 12 months)	
Cardiovascular screening - Lipid panel (every 5 years)	
Diabetes screening-FBS or GTT*	
*2 screening tests per year if diagnosed with pre-diabetes; 1 test per year if never tested OR tested previously but not diagnosed with pre-diabetes	
Women's Services	**Date or N/A**
Mammography screening (Age 40 and over - annually)	
Pap smear 9 (every 24 months or yearly if high risk)	
Pelvic exam (every 24 months or yearly if high risk)	
Diagnostic Services	**Date or N/A**
Bone mass measurement - DEXA (every 24 months)	
Glaucoma screening by an Optometrist (annually)	
Digital Rectal Exam - males (annually)	
Colorectal cancer screening (age 50 and over)*	
*FOBT (every 12 months)	
*Flex Sig (every 4 years of 120 months after screening colonoscopy for non-high risk)	
*Colonoscopy screening (every 10 years or 24 months for high risk)	
*Barium enema - as an alternative to Flex Sig (every 48 months or 24 months for high risk)	
Additional Recommendations	
Diabetes self-management training	
Medical nutrition therapy services	
Abdominal aortic aneurysm screening - MUST be referred through IPPE (once in a lifetime)	

Physician's signature: _____ **Date:** _____

For an all inclusive list see: "Medicare Preventative Services Quick Reference."

Reorder #26513 PP0008 (NMA)
Piedmont Graphics 02/19/16

COUNSELING AND/OR REFERRAL OF PREVENTATIVE SERVICES

NORTHSIDE HOSPITAL

Newtown Medical Associates

Create two copies of this page: One for the chart and one to give to the patient.

Patient's name: _____ **Date of Birth:** _____

Today's date: _____

Things that may be affecting your health:

- ☐ Alcohol
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty with daily activities
- ☐ Drug or Tobacco use
- ☐ Falls or Fall Risk
- ☐ Food Choices
- ☐ Hearing Loss
- ☐ Home Safety
- ☐ Lack of Physical Exercise
- ☐ Medicines
- ☐ Motor Vehicle Safety
- ☐ Pain
- ☐ Weight

Your doctor has referred you for:

Service	Name/Location	Date or N/A
☐ Counseling		
☐ Hearing Specialist		
☐ Nutrition Therapy		
☐ Diabetes Self-Management		
☐ Other		

☐ Please see attached list of Community Resources

Provider signature: _____ Date: _____

Reorder #26508 PP0002 (NMA)
Piedmont Graphics 02/19/16

RISK FACTORS/REFERRALS/INTERVENTIONS

NORTHSIDE HOSPITAL

Newtown Medical Associates

Patient's name: _____ **DOB:** _____

Today's date: _____

Instructions: Choose the best answer for how you felt over the past 2 weeks.

1. Are you basically satisfied with your life?	YES / NO
2. Have you dropped many of your activities and interests?	YES / NO
3. Do you feel that your life is empty?	YES / NO
4. Do you often get bored?	YES / NO
5. Are you in good spirits most of the time?	YES / NO
6. Are you afraid that something bad is going to happen to you?	YES / NO
7. Do you feel happy most of the time?	YES / NO
8. Do you often feel helpless?	YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things?	YES / NO
10. Do you feel you have more problems with memory than most?	YES / NO

___ Provider assessment: No further evaluation needed.

___ Referral: _____

Physician's signature: _____ **Date:** _____

Reorder #26686 PP0012 (NMA)
Piedmont Graphics 02/19/16

SCREENING FOR DEPRESSION

NORTHSIDE HOSPITAL

Newtown Medical Associates

Patient's name: _____ **DOB:** _____

Today's date: _____

1. Have you fallen before or been injured because of a fall?	YES / NO
2. Do you feel weaker than you used to or have less strength in your arms and legs?	YES / NO
3. Have you stopped doing daily activities or avoided exercise because you're afraid of falling?	YES / NO
4. Do you experience incontinence?	YES / NO
5. Has your hand strength decreased?	YES / NO
6. Has your eyesight diminished or do you have trouble seeing depth or seeing at night?	YES / NO
7. Do you feel dizzy when you stand up?	YES / NO
8. Have you experienced hearing loss?	YES / NO
9. Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps?	YES / NO
10. Do you feel unsteady on your feet or shuffle when you walk?	YES / NO

___ Provider assessment: No further evaluation needed.

___ Referral: _____

Physician's signature: _____ **Date:** _____

Reorder #26515 PP0011 (NMA)
Piedmont Graphics 02/19/16

PERSONAL RISK FACTORS FALL PREVENTION CHECKLIST

NORTHSIDE HOSPITAL

English - Spanish

Advance Directives: "Your Right To Decide"

Georgia law gives competent adults the right to make choices about their own health care. This includes the right to choose medical care, to refuse certain care or to stop care altogether. Georgia law also lets you choose someone to make health care choices for you if you are unable or unwilling to do so.

The best way for you to be in control of your medical treatment is to sign a ***'Georgia Advance Directive For Health Care'*** before you have an illness that prevents you from communicating your wishes.

What is an *'Advance Directive'*?
An advance directive is a legal form that lists your wishes about medical care and treatment. You may also name someone to make choices about your medical care and treatment if you can't. These forms are called advance directives since they are written in advance of a serious illness, to let other people know your wishes.

Do I have to have an advance directive?
No. Federal law makes it against the law for a hospital to refuse to take care of you because you do not have an advance directive.

What is the *'Georgia Advance Directive For Health Care'*?

The ***'Georgia Advance Directive For Health Care'*** is a legal document that that you complete. It is a standard form approved by the Georgia legislature. You can print a copy from Northside's website under Patient Information: Advance Directives. The form includes detailed instructions and guides you in answering important questions about how you want to be treated when you can no longer communicate or make decisions.

What is Northside Hospital's policy about advance directives?

- Northside will honor a patient's advance directive if it meets the requirements of Georgia law.
- Northside also recognizes and respects the right of competent patients to accept or refuse offered medical or surgical treatment, to the extent permitted by law.
- Northside Hospital's policy is that employees MAY NOT sign as a witness to any of these documents.
- If a patient becomes unstable in one of Northside's outpatient centers, including affiliated medical practices, Northside will initiate first line emergency care for the patient and transfer the patient to the emergency department via EMS. Healthcare providers in the emergency department will evaluate the patient's condition and decide if it is appropriate to follow the advance directive.

NORTHSIDE HOSPITAL

If I am pregnant, will my wishes in my advance directive be carried out?
That depends.

If the baby is developed enough that the baby could survive delivery, any instructions that would result in withholding or withdrawing life-sustaining treatments would not be honored.

Even if the baby is not developed enough to survive delivery, your treatment choices would not be honored unless you initial the statement on the ***'Georgia Advance Directive For Health'*** form that you want life sustaining treatment withheld or withdrawn when you are pregnant with a non-viable infant.

After I complete the advance directive, what do I do with it?
Once you have completed your advance directive and it is properly signed and witnessed, make sure you give a copy to:

- Your health care agent
- Your doctor or health care provider
- Your relatives.
- You may also complete the ***'Georgia Advance Directive For Health'*** Card included at the end of the form and keep it in your wallet.

This card says that you have an advance directive and whom to contact.

Georgia Advance Directive
For Health Card

Directives I have completed: (check one or more as appropriate)
___ Part I Healthcare Agent
___ Part 2 Treatment Preferences
___ Part 3 Guardianship

Person to Contact: _____
Address: _____
City:_____ State_____
Zip_____ Phone_____
Date_____
Signature_____

Georgia Advance Directive
For Health Card

Directives I have completed: (check one or more as appropriate)
___ Part I Healthcare Agent
___ Part 2 Treatment Preferences
___ Part 3 Guardianship

Person to Contact: _____
Address: _____
City:_____ State_____
Zip_____ Phone_____
Date_____
Signature_____

Not a Permanent Part of the Medical Record

NORTHSIDE HOSPITAL

NORTHSIDE HOSPITAL TIPS FOR FALL PREVENTION

Falls are a serious matter and can lead to injury. If you have fallen or experienced a near fall, please inform your physician or medical practitioner. The following items are intended to serve as basic strategies to prevent falls and improve your safety.

General Precautions:

- Wear your glasses as prescribed; wear your hearing aids if you have them.
- Use recommended walking device; do not use the furniture.
- Wear well-fitted shoes with low heels and non-slip soles. Do not wear flip-flops, mule style shoes or high heels. Do not walk around barefoot.
- Get up and down slowly to avoid dizziness or loss of balance.
- Have a cordless telephone easily accessible at all times.
- Ask for help, do not attempt activities that are too difficult.

Living Areas:

- Remove loose rugs and tack down loose carpeting/flooring to prevent tripping.
- Remove electrical cords, phone cords, and other clutter.
- Arrange furniture to provide clear pathways; if you use a walking aid make sure it will fit.
- Arrange home environment to avoid excessive bending or over reaching.
- Avoid slippery floors and walk carefully on uneven walking surfaces.
- Install night-lights in bathrooms, bedrooms and hallways.
- Use chairs and couches at proper height (not too low) and with arm rests to get in and out of them easily.
- Check or install hand railing on stairs or step-ups (inside and outside).

Bathrooms:

- Put non-slip strips in shower/tub.
- Install grab bars in the shower/tub and near toilet.
- Consider installing a shower seat (especially if history of falls or unsteady balance) and arrange toiletry items so they are at waist height.
- Install a night-light.
- Incorporate the use of dressing equipment such as a reacher or sock aid.

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INFORMATION ABOUT PAIN CONTROL

Pain Control

We want to partner with you to manage your pain. Decreasing your pain will help you rest and recover faster. There is no benefit from suffering with pain. With less pain you can:

- More easily move, cough, deep breathe or perform prescribed exercises
- Avoid problems of being in bed such as constipation, pneumonia or blood clots
- Regain strength earlier
- Heal faster
- Even return home sooner

Pain

Pain is your body's way of warning you there may be something wrong. This might be expected pain, such as pain after surgery or childbirth, or this may be pain you have lived with for a long time and the original cause is no longer present. Pain is caused from different things and everyone feels pain differently. The intensity and type of pain you feel may not be the same as someone else with the same problem or operation. We depend on you to tell us when you are not comfortable and how much pain you are having. Your nurse and doctor will be asking you questions about your pain and you can help by:

- Telling us when you have pain and where it is.
- Rating your pain on a scale from 0-10 where "0" is no pain and "10" is the worst pain you can imagine. This will help us know how well your treatment is working and whether to discuss the need for plan changes with your doctor.
- Describing how your pain feels with words like shooting, stabbing, burning, aching, throbbing, cramping, etc.
- Describing what makes your pain better or worse and whether it is always there or when it comes and goes away.
- Setting a comfort goal with your nurse/doctor on the same 0-10 scale. Remember it is not always possible to reach "0" or having no pain at all, but we would like to help you decrease your pain and be more comfortable.

Pain Treatment

There are different methods to help relieve pain. Your doctor is responsible for your pain management plan. Talk to your doctor about pain control methods that have worked well or not so well for you in the past. If you are in the hospital, ask your nurse for pain medicine when pain first begins. If you are home take it according to the plan you discussed with your doctor/nurse. It is easier to control pain when it first starts rather than after it becomes severe. There is no benefit in saving your medicine until your pain gets worse. Often the best pain management method is to take pain medicine on a regular schedule, asking for/taking more medicine or a stronger medicine if you should need it between the routine doses.

Medicine can be given in many different ways

- Pills or Liquids
  This is the most common way to receive pain medicine when you are able to eat and are not nauseated or vomiting. Relief may take 30-60 minutes.

- Shots (Injections)
  You may receive a shot (injection) of pain medicine through the skin. This method may be used if you are nauseated or unable to eat. Pain is usually relieved in 30-45 minutes, but relief may wear off quickly and the shot often needs to be repeated.

- Injections into a Vein
  A nurse may give you medicine through an intravenous (IV) tube or you may give it yourself with a special pump called Patient Controlled Analgesia (PCA). When given IV, pain medicine provides relief within a few minutes.

- Epidural or Spinal Injections
  Medicine can be given through a small tube in your back. This is often used during surgery or when having a baby, but can also be given after surgery/childbirth or for patients with severe chronic pain by using a special pump that allows you to give yourself doses of medicine as you need them.

- Skin Patches
  Medicine also may be provided by a small skin patch that delivers a constant supply of pain reliever through the skin. This is most useful for chronic pain.

Medicine Side Effects

Itching, nausea, vomiting, sleepiness and constipation are the most common side effects of pain medicines. Not all people experience these, but if you do it is important to tell us early so these effects can be easily managed. Constipation can be a big problem with some pain medicines and laxatives may need to be started the same time as these medicines. Please ask your nurse or doctor if you should take a laxative. If you are using a pain medicine pump, it is important that only you push the dose button. Having a family member or friend push your button to give you a dose could make you too sleepy or even slow your breathing.

Many people are worried about getting "hooked" or addicted to pain medicine. Studies show that becoming addicted while taking pain medicine is very rare. After taking pain medicine for a long time, it is possible to become "tolerant" and need more medicine for relief. This is different than addiction. Please discuss any concerns about addiction with your doctor.

Please let your doctor/nurse know of any over-the-counter medicines, herbs or vitamins/minerals you are taking. They may effect how your pain medicine works or cause a dangerous reaction.

Non-Drug Pain Management

These methods are meant to be used in addition to, not instead of medicine. Success will be different for everyone, but may make your pain more tolerable, improve your mood, reduce distress, give you a sense of control or help you rest/sleep. These methods include:

- Cold or heat therapy
- Massage or vibration
- Music
- Deep Breathing/Relaxation
- Peaceful Imaging/Meditation
- Distraction

Pain control is a very important part of your care and will help in your healing. Please talk with your doctor or nurse if your pain is getting worse or your treatment plan is not working. At Northside Hospital, we want to partner with you to manage your pain.

Patient Name _____
Date of birth _____ /_____ /_____
Month Day Year

Agency on Aging: The Georgia area local Agency on Aging can help you find information about transportation services, Meals on Wheels, classes on healthy living and more.

Region 2 Counties: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White

Phone: 770-538-2650
Web: www.legacylink.org

Region 3 Counties: Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale

Phone: 404-463-3333
Web: www.agewiseconnection.com

Live Healthy Georgia: LHG (a division of Georgia Department of Public Health) offers community assistance and guidance for living healthier in areas such as disease prevention, eating healthy and alcohol and tobacco abuse.

Web: www.livehealthygeorgia.org

Tobacco quit line: 1-877-270-STOP

United Way of Greater Atlanta: Offers assistance in areas of education, health and many more.

Phone: 404-527-7200
Web: www.unitedwayatlanta.org

YMCA of Metro Atlanta: Offers physical activities, self-management programs and more at many YMCA locations.
Web: www.ymcaatlanta.org

Cowart Family/Ashford Dunwoody
Phone: 770-451-9622
Web: www.cay.ymcaatlanta.org

Ed Isakson Alpharetta Family YMCA
Phone: 770-664-1220
Web: www.iay.ymcaatlanta.org

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NORTHSIDE HOSPITAL

Newtown Medical Associates

Patient Name _____

Date of birth _____ /_____ /_____
Month Day Year

What *is* included in the Annual Wellness Visit benefit?

Medicare requires that providers do the following for the Annual Wellness Visit:

- Obtain the patient's personal and family medical history
- Obtain a list of healthcare providers and suppliers involved in the patient's care
- Measure Vital Signs, such as blood pressure, height, weight, and waist circumference
- Screen for cognitive impairment (dementia or psychosis)
- Screen for depression using standardized questionnaires
- Provide a written schedule for each patient of government recommended screening tests and preventive services for the next 5 - 10 years
- Establish a list of risk factors for each individual that might benefit from intervention, such as obesity, risk of falls, depression, alcohol or tobacco use, and physical inactivity.
- Establish a list of treatment options for these risk factors including risks and benefits of these options
- Provide personal advice regarding these risk factors, or referral to a health educator, counselor, or community-based program for lifestyle interventions
- Provide advance care planning regarding end of life issues, if the patient wishes

What is *not* included in the Annual Wellness Visit benefit?

The Annual Wellness Visit benefit is intended for risk factor identification and preventive services planning. It is not intended to cover evaluation of symptoms or medical problems a patient may have, and it is not intended for treatment of any disease a patient may have. Examples of things not covered in the Annual Wellness Visit are:

- Refills of chronic medications or prescription of new medications are not included
- Evaluation of status of chronic diseases such as diabetes, high blood pressure, high cholesterol, heart disease, arthritis, urinary symptoms are not included
- The actual performance of a preventive service, such as performing a Pap smear or prostate exam. (Medicare may cover these services, but they are not covered under the Annual Wellness Benefit, and are supposed to be billed separately.)
- An actual physical exam (such as looking at the skin, listening to the heart and lungs, examining the abdomen) are not included
- Blood tests to follow any condition the patient is known to have, or blood tests to diagnose any condition except for the few specific screening tests Medicare covers. For example, Medicare covers a screening PSA (prostate cancer blood test) every year for men, but this has traditionally been subject to payment of co-insurance and deductibles, and is not currently defined as part of the Annual Wellness Benefit. Patients with prostate cancer who need PSA tests done more often than once a year still have Medicare coverage for these tests, but the payment is not covered under the Annual Wellness Benefit.