Carolina Urology Associates
Columbus Regional Health Network

For Office Use Only:
MRN#: ___________

Legal Name: ______________________ **SSN:** ____________ **Date:** ____________ **DOB:** ____________

Sex: M / F **Primary Care Provider:** ____________________ **Referred by:** ________________________

Home Address: ____
Address City ST Zip Code

Home Phone: ________________ **Work Phone:** ________________ **Mobile Phone:** _________________

E-mail address: _____________________________________ **Insurance Name:** _______________________

Employer Name: _____________________

Employer Address: ____
Address City ST Zip Code

Emergency Contact:

Name: _____________________ Relationship: _____________________

Home Phone: ________________ Work Phone: ________________ Mobile Phone: _________________

Responsible Party if Different:

Name: ______________________ SSN: ____________ DOB: ____________

Reason for Visit:

___Urinary Tract Infection
___Difficulty Urinating
___Prostate Problems
___Kidney Mass
___Elevated PSA
___Difficulty with Erections
___Blood in Urine
___Frequent Urination
___Strong Urge to Urinate
___Urine Leakage
___Weak Urine Stream
___Urinating at Night
___Low Sexual Desire
___Discharge
___Testicular Pain
___Pain with Urination
___Elevated PSA
___Other:

When does it occur?___________________________
How long has this been going on?_________________
Does anything make it better?___________________

Do you have any of the following?

Y or N	Fever or Chills	Y or N	Cough	Y or N	Back Pain
Y or N	Fatigue	Y or N	Shortness of Breath	Y or N	Nipple Discharge
Y or N	Headaches	Y or N	Nausea	Y or N	Bleeding Problems
Y or N	Weight Loss	Y or N	Vomiting	Y or N	Depression
Y or N	Changes in Vision	Y or N	Constipation	Y or N	Anxiety
Y or N	Sore Throat	Y or N	Diarrhea	Y or N	Pain During Sex
Y or N	Chest Pain	Y or N	Abdominal Pain		

Past Medical History/Illness: (Check all that apply)

__ Asthma
__ High Blood Pressure
__ Liver Disease (Hepatitis)
__ Rheumatoid Arthritis
__ Blood Clots
__ Kidney Disease
__ Vascular Disease
__ Thyroid Disorder
__ Heart Attack
__ Stroke
__ Seizures
__ Diabetes
__ Gout
__ Heart Failure
__ HIV/AIDS
__ Cancer, Type/Stage: ________________
__ Blood/Bleeding Problems
__ High Cholesterol
__Stomach Ulcers

Past Surgery: (Check all that apply)

__ Heart Bypass
__ Prostate
__ Tendon/Ligament Repair
__ Tubal Ligation
__ Joint Replacement
__ Other: ________________
__ Hernia
__ Fractures
__ Bowel Surgery
__ Gallbladder Removal
__ Appendectomy
__ Hysterectomy

Turn Page Over

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Social History: (Circle Y or N)

Do you smoke? **Y / N** How much: ________ Have you ever smoked? **Y / N** How much: ________
Do you consume alcohol? **Y / N** How much: ________ Employment Status: **working, retired, disabled** Job: ________
Relationship Status: **single, married, divorced, widowed** Have Kids: **Y / N**

Circle Below:

Mother: Deceased (Yes or No) Age of death ________ Cause of death ________________
Father: Deceased (Yes or No) Age of death ________ Cause of death ________________

Family History: Who in your family has the following? (Please write M for Mother, F for Father)

____ Asthma ____ Diabetes ____ Heart Attack ____ High Cholesterol ____ Glaucoma
____ COPD ____ Kidney Failure ____ Stroke ____ High Blood Pressure ____ Vascular Disease
____ Bladder Cancer ____ Kidney Cancer ____ Prostate Cancer

What pharmacy do you use? ____

Please list your medications and doses below: (Include any nonprescription medications)

____

____

Are you allergic to any medications? Yes or No

Please list medication allergies and your reaction: Nausea / itching / hives / difficulty breathing / other

____

____

Any allergy to: Iodine **Y / N** Metal **Y / N** Latex **Y / N**

Authorization, Assignment of Benefits, and Referral Medical Release:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly o Columbus Regional Health Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: ____ Date: ____________________

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by the physicians of the nature and purpose of an proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: ____ Date: ____________________

Thank you!

Patient Name: ______________________ Date of birth: ________ Date completed _______

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?.	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	1 Time	2 Times	3 Times	4 Times	5 Times	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: ______________________________ TODAY'S DATE: ___________

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	DID NOT ATTEMPT INTERCOURSE	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. TOTAL: ___________

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED 8-11 Moderate ED 12-16 Mild to Moderate ED 17-21 Mild ED

Carolina Urology Associates

Consent for Communication for Involvement of Care

I, the undersigned, do herby consent and request that Carolina Urology Associates communicate with or release health information concerning me, if communication is in my best interest and is only information that is directly relevant to designated individual's involvement with my health care and treatment decisions.

Patient's Name X______________________________ DOB X__________

1. Name and address of person who I want to have health information as outlined above.

Name______________________ Relationship to Patient______________

Address: ____

____

Phone #______________________

2. Name and address of person who I want to have health information as outlined above.

Name______________________ Relationship to Patient______________

Address: ____

____

Phone #______________________

3. Name and address of person who I want to have health information as outlined above.

Name______________________ Relationship to Patient______________

Address: ____

____

Phone #______________________

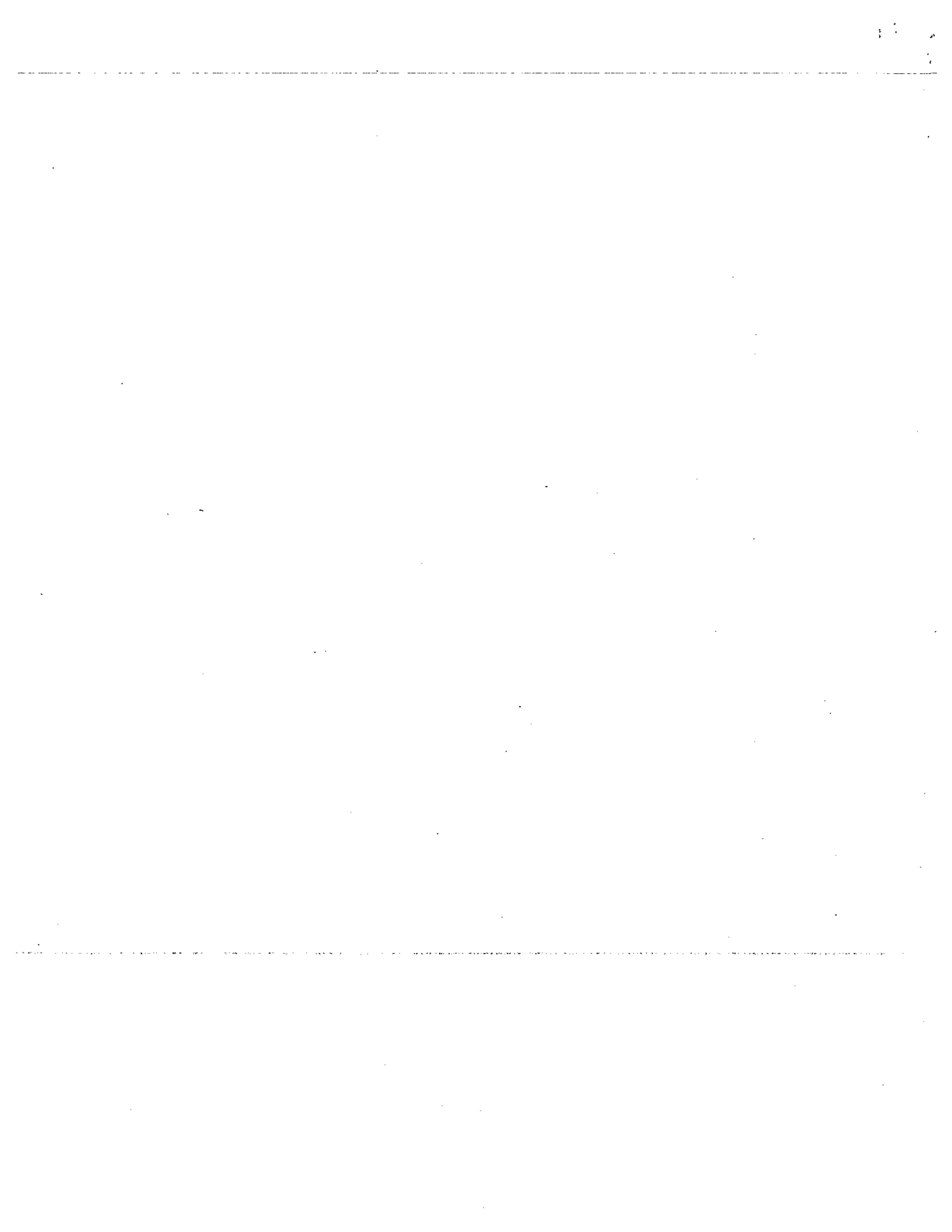
X______________________ X______________________

Signature of Patient or Authorized Party / Date Printed Name

I do not grant consent for anyone to be given information regarding my health care or treatment except required by law.

______________________ ______________________

Signature of Patient or Authorized Party / Date Printed Name



Columbus Regional Health Network

ACKNOWLEDGEMENT FORM

Medical Records # ________________

Patient's Name: X ______________________________ Date of Birth X_____/______/______
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: X ______________________________________ Date: X ________________
(Patient or Authorized Representative)

X Relationship to Patient: _________ Self ___________ Spouse __________ Other ___________

Reason Patient Unable/Unwilling to Sign: ______________________________________

____

ACKNOWLEDGEMENT FORM

DOCUMENTO DE RECONOCIMIENTO DE COLUMBUS REGIONAL HEALTH NETWORK

Numero de Registro Medico ________________

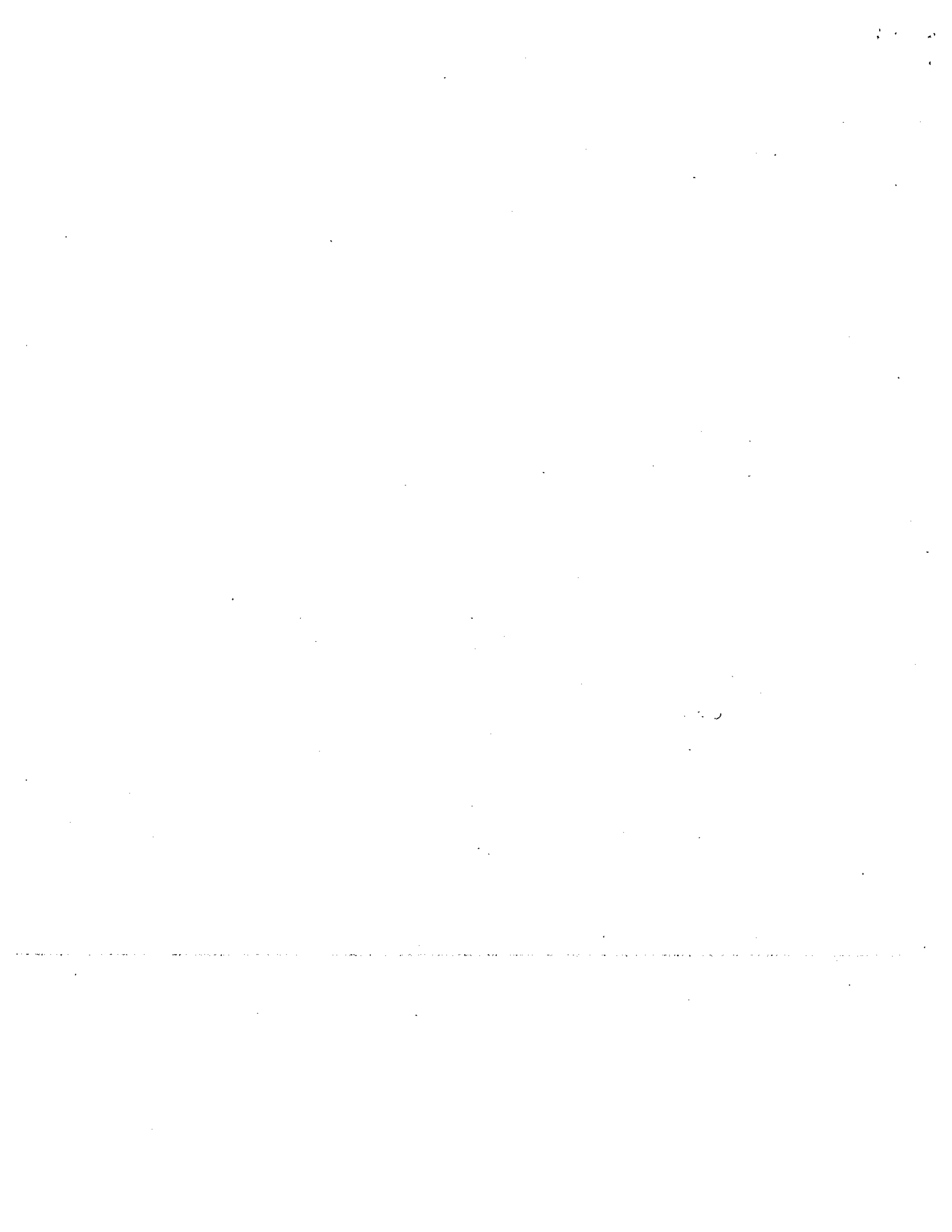
Nombre del Paciente ____________________________ Fecha de Nacimiento _____/_____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: ________________________________ Fecha: ______________________________
(Paciente o Representante Autorizado)

Relacion al Paciente: ________ Mismo _________ Esposo (a) __________ Otro ____________

Razon Por la Cual El Paciente No Puede/No Desea Firmar: ____________________________



PATIENT RIGHTS

1. A patient has the right to respectful care given by competent personnel.

2. A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.

3. A patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly.

4. A patient has the right to have all records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.

5. A patient has the right to know what facility rules and regulations apply to his conduct as a patient.

6. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.

7. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

8. The patient has the right to full information in laymen's terms, concerning his diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's designee.

9. Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.

10. A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent must be obtained prior to actual participation in such program and the patient or legally responsible party, may, at any time, refuse to continue in any such program to which he has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in accord with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations under 21 CFR Parts 50 and 56. For any research study proposed for conduct under a FDA "Exception from Informed Consent Requirements for Emergency Research" or a HHS "Emergency Research Consent Waiver" in which informed consent is waived but community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study also must verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB reviewing the research study has authorized the start of the community consultation process required by the federal regulations for emergency research, but before the beginning of that process, notice of the proposed research study by the facility shall be provided to the North Carolina Medical Care Commission. The notice shall include:

- the title of the research study;
- a description of the research study, including a description of the population to be enrolled;
- a description of the planned community consultation process, including currently proposed meeting dates and times;
- an explanation of the way that people choosing not to participate in the research study may opt out; and
- contact information including mailing address and phone number for the IRB and the principal investigator:.

The Medical Care Commission may publish all or part of the above information in the North Carolina Register, and may require the institution proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.

11. A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to the extent permitted by law, and a physician shall inform the patient of his right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.

12. A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.

13. A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual orientation, gender identity, national origin or source of payment.

14. A patient who does not speak English or is hearing impaired shall have access, when possible, to a qualified medical interpreter (for foreign language or hearing impairment) at no cost, when necessary and possible.

15. The facility shall provide a patient, or patient designee, upon request, access to all information contained in the patient's medical records. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason. A patient's designee may have access to the information in the patient's medical records even if the attending physician restricts the patient's access to those records.

16. A patient has the right not to be awakened by hospital staff unless it is medically necessary.

17. The patient has the right to be free from needless duplication of medical and nursing procedures.

18. The patient has the right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.

19. When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

20. The patient has the right to examine and receive a detailed explanation of his bill.

21. The patient has a right to full information and counseling on the availability of known financial resources for his health care.

22. A patient has the right to expect that the facility will provide a mechanism whereby he is informed upon discharge of his continuing health care requirements following discharge and the means for meeting them.

23. A patient shall not be denied the right of access to an individual or agency who is authorized to act on his behalf to assert or protect the rights set out in this Section

PATIENT RIGHTS

24. A patient, or when appropriate, the patient's representative has the right to be informed of his rights at the earliest possible time in the course of his hospitalization.

25. A patient, and when appropriate, the patient's representative has the right to have any concerns, complaints and grievances addressed. Sharing concerns, complaints and grievances will not compromise a patient's care, treatment or services.

- If a patient has a concern, complaint, or grievance, he may contact his nurse, the nursing supervisor, or call the patient advocate at 910-642-1747.
- If the patient issues are not satisfactorily addressed while the patient remains hospitalized, the investigation will continue. The intent is to provide the patient a letter outlining the findings within seven days.
- If a patient chooses to identify a concern, complaint, or grievance after discharge, he may call the patient advocate at 910-642-1747 or write a letter to Columbus Regional Healthcare System 500 Jefferson St Whiteville, NC 28472
- The patient has the right to directly contact the North Carolina Department of Health and Human Services (State Survey Agency) or the Joint Commission on Accreditation of Healthcare Organizations.

NC Division of Health Services Regulation
Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711.
www.2.ncdhhs.gov/dhsr/ciu/complaintintake.html 1-800-624-3004

The Joint Commission
Email: complaint@jointcommission.org
1-800-994-6610

26. The patient has the right to participate in the development and implementation of his plan of care, including his inpatient treatment/care plan, outpatient treatment/care plan, discharge care plan, and pain management plan.

27. The patient, or when appropriate, the patient's representative has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. Making informed decisions includes the development of their plan of care, medical and surgical interventions (e.g. deciding whether to sign a surgical consent), pain management, patient care issues and discharge planning.

28. The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.

29. The patient has the right to have a family member or representative of his or her choice and his own physician notified promptly of his admission to the hospital.

30. The patient has the right to personal privacy. Privacy includes a right to respect, dignity, and comfort as well as privacy during personal hygiene activities (e.g. toileting, bathing, dressing), during medical/nursing treatments, and when requested as appropriate. It also includes limiting release or disclosure of patient information such as patient's presence in facility, location in hospital, or personal information.

31. The patient has the right to receive care in a safe setting. A safe setting includes environmental safety, infection control, security, protection of emotional health and safety, including respect, dignity, and comfort, as well as physical safety.

32. The patient has the right to be free from all forms of abuse or harassment. This includes abuse, neglect, or harassment from staff, other patients, and visitors.

33. The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

34. The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

35. A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient by blood or by marriage.

PATIENT RESPONSIBILITIES

1. Patients, and their families when appropriate, are responsible for providing correct and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.

2. Patients and their families are responsible for reporting unexpected changes in their condition or concerns about their care to the doctor or nurse taking care of them.

3. Patients and their families are responsible for asking questions when they do not understand their care, treatment, and service or what they are expected to do.

4. Patients and their families are responsible for following the care, treatment, and service plans that have been developed by the healthcare team and agreed to by the patient.

5. Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.

6. Patients and their families are responsible for following the hospital's rules and regulations.

7. Patients and their families are responsible for being considerate of the hospital's staff and property, as well as other patients and their property.

8. Patients and their families are responsible to promptly meet any financial obligation agreed to with the hospital.