THE CENTER FOR DERMATOLOGY AND PLASTIC SURGERY
at Springbrook

Adult Health History Questionnaire

FOR INTERNAL USE ONLY

Date of Visit: _____

Account #: _____

PLEASE PRINT CLEARLY *All answers given on this questionnaire are strictly confidential and will become part of your medical record.*

Patient Name *(Last, First, M.I.):* **Age** **Date of Birth** ☐ **Male** ☐ **Female**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referring Physician: Primary Care Physician:

Reason for Visit:

SURGERIES AND HOSPITALIZATIONS

Year:	Type of Surgery and Reason for Surgery:	Hospital/Physician's Name:

DRUG / FOOD ALLERGIES

Name of Drug/Food:	Type of Reaction:

PERSONAL HEALTH HABITS

Tobacco	Do you use tobacco? ☐ Yes ☐ No ☐ Former Use	Number of years you have used tobacco: _____
	Type: ☐ Cigarettes – # packs/day_____	☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____
	Have you tried to quit? ☐ Yes ☐ No	Year you quit using tobacco:_____
Alcohol	Do you drink alcohol? ☐ Yes ☐ No ☐ Former Use	Type:_____ Amount: Daily____ Weekly____ Monthly____
Drugs	Do you use drugs other than prescription medications? ☐ Yes ☐ No ☐ Past Use	Type:_____ Amount: Daily____ Weekly____ Monthly____

Adult Health History Questionnaire *continued*

ADULT PATIENT AND FAMILY HEALTH HISTORY

Please check if you or a close member of your family has had any of the above.	*Airway Problems*	*Alzheimer's*	*Arthritis*	*Asthma*	*Bleeding Disorder*	*Blood Vessel Disease*	*Cancer*	*Depression*	*Diabetes*	*Heart Disease*	*Hepatitis*	*High Blood Pressure*	*High Cholesterol*	*Kidney Disease*	*Mental Illness*	*Migraines*	*Osteoporosis*	*Overweight*	*Seizure Disorder*	*Stroke*	*Other*
RELATION																					
Mother																					
Maternal Grandmother																					
Maternal Grandfather																					
Father																					
Paternal Grandmother																					
Paternal Grandfather																					
Sister																					
Brother																					
Other																					

WOMEN ONLY

Currently pregnant? ☐ Yes ☐ No

Number of Pregnancies:_____

Number of live births:_____

Number of C-Sections:_____

Currently Nursing: ☐ Yes ☐ No

Using birth control? ☐ Yes ☐ No

If yes, list type of birth control:

Have you had a hysterectomy? ☐ Yes ☐ No

Date:_____

Reason:_____

Name of gynecologist:

Date of last mammogram:_____

Please list all medications, vitamins, and/or herbs that you are taking.

Include any medications that are swallowed, injected, inhaled, or applied to the skin.

Current Medication:	Dose:	How often the medication is taken:

Pharmacy:	City:	Street:

Adult Health History Questionnaire *continued*

REVIEW OF ADULT SYSTEMS

Please check box Yes or No. Any positive responses will be discussed with you by Dr. Becker.	Yes	No	Specify type, if known
☐ Abnormal Bleeding	☐	☐	
☐ Prolonged Bleeding with Tooth Extraction	☐	☐	
☐ Acid Reflux	☐	☐	
☐ AIDS/HIV –List Type	☐	☐	
☐ Alzheimer's	☐	☐	
☐ Arthritis	☐	☐	
☐ Asthma	☐	☐	
☐ Blood Disease	☐	☐	
☐ Brain Disease	☐	☐	
☐ Bronchitis	☐	☐	
☐ Bruise Easily	☐	☐	
☐ Cancer –List Type	☐	☐	
☐ Chest Pain	☐	☐	
☐ Depression	☐	☐	
☐ Diabetes	☐	☐	
☐ Emphysema/ COPD	☐	☐	
☐ Hardening of the Arteries	☐	☐	
☐ Heart Attack	☐	☐	
☐ Heart Disease	☐	☐	
☐ Heart Failure	☐	☐	
☐ Hepatitis (A,B,C) –List Type	☐	☐	
☐ Other Liver Disease –List Type	☐	☐	
☐ High Blood Pressure	☐	☐	
☐ High Cholesterol	☐	☐	
☐ GI Disease (Bowel, Stomach, Gallbladder)	☐	☐	
☐ Glaucoma	☐	☐	
☐ Kidney Disease	☐	☐	
☐ Lung Disease	☐	☐	
☐ Mental Illness	☐	☐	
☐ Migraines	☐	☐	
☐ Nerve Disease	☐	☐	
☐ Respiratory Disease	☐	☐	
☐ Problems Opening Mouth Wide	☐	☐	
☐ Problems Turning Head From Side to Side	☐	☐	
☐ Rheumatic Fever	☐	☐	
☐ Sickle Cell Disease	☐	☐	
☐ Seizure Disorder	☐	☐	
☐ Spinal Cord Disease	☐	☐	
☐ Stroke	☐	☐	
☐ Thyroid Disorder –List Type	☐	☐	

PLEASE LIST ANY OTHER CONDITIONS OR IMPORTANT HEALTH INFORMATION:

Adult Health History Questionnaire

THE CENTER FOR DERMATOLOGY
AND PLASTIC SURGERY
at Springbrook

S. Matthew Becker MD • 220 Associates Blvd., Alcoa, TN 37701 • 865-238-6400

FOR INTERNAL USE ONLY

Date of Visit: _____

Account #: _____

PLEASE PRINT CLEARLY *All answers given on this questionnaire are strictly confidential and will become part of your medical record.*

Patient Name *(Last, First, M.I.)* **Age** **Date of Birth** ❒ **Male** ❒ **Female**

Smoking Status: ❒ Yes ❒ No ❒ Former user	Number of years you have used tobacco:
Type: ❒ Cigarettes / packs per day: ❒ Chew / times per day: ❒ Pipe / number per day: ❒ Cigars / number per day:	
Have you tried to quit smoking? ❒ Yes ❒ No	Reason for Visit:

DRUG / FOOD ALLERGIES

Name of Drug/Food:	Type of Reaction:

Please list all medications, vitamins and/or herbs that you are taking.

Include any medications that are swallowed, injected, inhaled or applied to the skin.

Current Medication:	Dose:	How often the medication is taken:

Pharmacy:	City:	Street:

THE CENTER FOR DERMATOLOGY
AND PLASTIC SURGERY
at Springbrook

Patient Information Form

PLEASE PRINT CLEARLY

☐ MALE ☐ FEMALE

DATE OF BIRTH

_____/_____/_____

SOCIAL SECURITY NO.

EMERGENCY PHONE

Name

Address

City State Zip

Home Phone Cell Phone

Work Phone Email Address

Race/Ethnicity Primary Language

Employer

Primary Care Physician Referring Physician

Referring Physician Address Telephone No.

Do you have insurance? ☐ YES ☐ NO Primary Insurance Company

Relationship to Policy Holder ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Name of Policy Holder DOB

Employer Policy Holder Social Security No.

Secondary Insurance Company

Relationship to Policy Holder ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Name of Policy Holder DOB

Employer Policy Holder Social Security No.

MESSAGES: May we leave a message at the contact number you indicated on your registration form regarding lab results, prescriptions, verification of appointment and/or test results?

☐ **YES** ☐ **NO**

If no, please specify a number(s) where we may contact you:

_____

_____

_____

PERMISSION FOR DISCLOSURE: I give my permission to disclose my protected health information to the following people:

Name Relationship DOB

Name Relationship DOB

Name Relationship DOB

_____

Signature of Patient or Patient's Representative Date

_____

Printed name of Patient's Representative

_____

Relationship to Patient

Blount Memorial Hospital
907 East Lamar Alexander Parkway
Maryville, TN 37804-5016 865-983-7211

Place Patient Label Here

Acknowledgement of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME _____
Please Print

RELATIONSHIP TO PATIENT _____

SIGNATURE _____ DATE _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices,* but was unable to do so as documented below:

Date	**Reason**
	[ ] Emergency [ ] Patient refused
	[ ] NOP Mailed to Patient and not returned
Initials	[ ] Other _____
	_____

Blount Memorial Hospital
907 East Lamar Alexander Parkway
Maryville, TN 37804-5016 865-983-7211

Blount Memorial Hospital Consent/Release Form

Place Patient Label Here
or
Print Patient's Name
and Date of Birth

CONSENT FOR TREATMENT, PROCEDURES, TESTS AND CARE: I KNOWINGLY CONSENT TO ANY TREATMENT, PROCEDURES, TESTS AND CARE ("CARE") FOR WHICH BLOUNT MEMORIAL HOSPITAL AND/OR ITS ENTITIES ("FACILITY") IS REQUESTED TO PROVIDE ME, INCLUDING CARE AT FACILITY BOTH AS AN INPATIENT OR OUTPATIENT. I UNDERSTAND MY RIGHT TO QUESTION OR REFUSE CARE. BY REFUSING CARE, I UNDERSTAND I HAVE RELEASED AND WAIVED ANY LIABILITY OF FACILITY, ITS EMPLOYEES, ITS AGENTS, AND MY PHYSICIAN. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT, CARE OR EXAMINATIONS IN THE HOSPITAL. I AUTHORIZE BLOUNT MEMORIAL HOSPITAL, MARYVILLE, TN TO RETAIN, PRESERVE AND USE FOR SCIENTIFIC OR TEACHING PURPOSES, OR DISPOSE OF AT ITS CONVENIENCE ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY.

ASSIGNMENT OF BENEFITS: I AUTHORIZE DIRECT PAYMENT TO FACILITY OF ALL HOSPITALIZATION/FACILITY BENEFITS OTHERWISE PAYABLE TO ME BY ANY PAYOR INCLUDING MEDICARE, TENNCARE, CHAMPUS/CHAMPVA, ANY OTHER THIRD PARTY PAYOR AND MY PERSONAL INSURANCE, INCLUDING MEDICAL PAYMENT BENEFITS, PERSONAL INJURY PROTECTION, UNINSURED AND UNDERINSURED BENEFITS. I UNDERSTAND THAT MY INSURANCE COMPANY MAY NOT COVER ALL SERVICES AND CARE, AND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES AND/OR EXPENSES INCLUDING ANY DRUGS MEDICARE CONSIDERS SELF-ADMINISTERED. I FURTHER UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLES AND/OR CO-INSURANCE PAYMENTS ASSOCIATED WITH MY CARE, AND THAT IT IS MY RESPONSIBILITY TO ASSURE PROPER NOTIFICATION/AUTHORIZATION IS OBTAINED FROM MY INSURANCE COMPANY IF REQUIRED FOR PAYMENT. I UNDERSTAND THAT ANY FAILURE TO COMPLY WITH PROPER NOTIFICATION/AUTHORIZATION REQUIREMENT CAN RESULT IN MY BEING PERSONALLY RESPONSIBLE FOR ALL CARE CHARGES AT FACILITY.

PAYMENT OF BILLS: THE UNDERSIGNED AGREES, WHEN HE/SHE SIGNS AS PATIENT, PATIENT'S AGENT, ATTORNEY, GUARDIAN, CONSERVATOR, OR OTHER RESPONSIBLE PARTY, THE PATIENT IS LIABLE FOR THE PAYMENT OF THE FACILITY ACCOUNT IN ACCORDANCE WITH FACILITY'S RATES AND TERMS. I FURTHER UNDERSTAND ANY DELINQUENT ACCOUNT WILL BE SENT FOR COLLECTION EFFORTS AFTER NOTICE, AND THAT I AGREE ANY COLLECTION COSTS OR FEES, INCLUDING ATTORNEY FEES, ASSOCIATED WITH THE COLLECTION OF MY ACCOUNT ARE MY RESPONSIBILITY, AND MAY BE ADDED TO ANY UNPAID AMOUNT OWED FACILITY FOR MY CARE. I UNDERSTAND THAT FINANCIAL ASSISTANCE IS AVAILABLE TO THOSE WHO QUALIFY AND I CAN GET ADDITIONAL INFORMATION BY CONTACTING THE BUSINESS OFFICE. I AGREE, IN ORDER TO SERVICE MY ACCOUNT, OR TO COLLECT ANY AMOUNTS I MAY OWE, THE FACILITY MAY CONTACT ME BY TELEPHONE AT ANY TELEPHONE NUMBER ASSOCIATED WITH MY ACCOUNT, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO ME. THE FACILITY MAY ALSO CONTACT ME BY SENDING TEXT MESSAGES OR E-MAILS, USING ANY E-MAIL ADDRESS I PROVIDE TO THEM. METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICIAL VOICE MESSAGES AND/OR USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE. I ALSO UNDERSTAND THAT MY CONTACT INFORMATION MAY BE SHARED WITH ANCILLARY PROVIDERS FOR TREATMENT AND PAYMENT PURPOSES.

HEALTH INFORMATION EXCHANGE: I UNDERSTAND AND AGREE THAT MY PROTECTED HEALTH INFORMATION MAY BE ACCESSED, USED AND DISCLOSED THROUGH A REGIONAL HEALTH INFORMATION ORGANIZATION (RHIO). THE RHIO CURRENTLY AVAILABLE IN OUR AREA IS NAMED eTHIN (EAST TENNESSEE HEALTH INFORMATION NETWORK). FURTHER, I UNDERSTAND THAT THE FUNCTION OF eTHIN IS TO SHARE HEALTH INFORMATION ACROSS THE AREA, TO FACILITATE BETTER CARE BETWEEN HEALTH CARE PROVIDERS IN THE REGION AND FACILITATE BETTER MEDICAL CARE FOR PATIENTS LIVING IN EAST TENNESSEE. AS SUCH, I UNDERSTAND THAT ONLY THOSE HEALTH CARE PROVIDERS WHO ARE TREATING ME AND PARTICIPATING IN eTHIN MAY ELECTRONICALLY ACCESS MY HEALTH INFORMATION FROM ANY PROVIDER (ie PHYSICIAN, HOSPITAL, CLINIC OR OTHER HEALTH CARE PROVIDER) PARTICIPATING IN eTHIN. AS OUTLINED IN THE HEALTH INFORMATION EXCHANGE PATIENT RELEASE FORM, I UNDERSTAND I HAVE OPTIONS REGARDING MY PARTICIPATION.

NOTIFICATION OF FAMILY, DURABLE POWER OF ATTORNEY FOR HEALTHCARE, EMERGENCY CONTACT OR SURROGATE: IN THE EVENT THERE IS A SIGNIFICANT CHANGE IN MY CONDITION OR I EXPERIENCE A FALL OR INJURY UNLESS I SPECIFICALLY TELL MY HEALTHCARE PROVIDERS NOT TO DO SO, I UNDERSTAND THAT A MEMBER OF MY FAMILY, DURABLE POWER OF ATTORNEY FOR HEALTHCARE, EMERGENCY CONTACT OR SURROGATE CAN BE NOTIFIED. THIS IS FOR MY SAFETY AND CONTINUUM OF CARE.

TOBACCO FREE CAMPUS: I UNDERSTAND THAT BLOUNT MEMORIAL HOSPITAL FACILITIES ARE TOBACCO FREE, BOTH INSIDE AND OUTSIDE THE BUILDINGS. I AGREE TO REFRAIN FROM SMOKING OR USING TOBACCO PRODUCTS IN OR ON ANY BLOUNT MEMORIAL PROPERTY. IF DEEMED NECESSARY AND REQUESTED I AGREE TO GIVE ALL TOBACCO PRODUCTS AND SMOKING MATERIALS, INCLUDING MATCHES AND LIGHTERS, TO MY FAMILY TO REMOVE FROM THE PROPERTY OR TO THE NURSING STAFF TO DISPOSE OF FOR SAFETY REASONS. I UNDERSTAND I WILL NOT BE PERMITTED TO LEAVE THE PROPERTY TO USE TOBACCO IF AN INPATIENT. I FURTHER UNDERSTAND AND AGREE THAT IF I DO NOT ABIDE BY THE TOBACCO-FREE RULE, I MAY BE ASKED TO TRANSFER TO ANOTHER MEDICAL FACILITY AND I AGREE TO SUCH TRANSFER AND WILL BE RESPONSIBLE FOR MAKING SUCH TRANSFER ARRANGEMENTS.

CONSENT FOR BLOOD TESTING: TO PROTECT AGAINST POSSIBLE TRANSMISSION OF BLOODBORNE-DISEASES, INCLUDING BUT NOT LIMITED TO HEPATITIS-B, HEPATITIS-C, OR ACQUIRED IMMUNE DEFICIENCY SYNDROMS (AIDS), I UNDERSTAND THAT IT MAY BE NECESSARY TO TEST MY BLOOD WHILE I AM PATIENT AT THIS FACILITY. IF, FOR EXAMPLE, A FACILITY EMPLOYEE IS STUCK BY A NEEDLE WHILE DRAWING BLOOD OR SUSTAINS A SCAPEL INJURY, I UNDERSTAND, AND CONSENT, THAT MY BLOOD, AS WELL AS THE EMPLOYEE'S BLOOD, WILL BE TESTED. I FURTHER UNDERSTAND THAT THE TESTING WILL BE AT NO CHARGE TO ME, THE RESULTS WILL BE KEPT CONFIDENTIAL AND MY PHYSICIAN WILL INFORM ME OF THE RESULT.

PERSONAL ITEMS/PROSTHESES AND VALUABLES: I UNDERSTAND THAT THE FACILITY WILL NOT BE RESPONSIBLE FOR THE LOSS OF OR DAMAGE OF PROSTHESES OR PERSONAL ITEMS SUCH AS GLASSES, HEARING AIDS, CONTACT LENSES, DENTURES, PERSONAL CLOTHING OR PERSONAL MEDICATIONS KEPT IN MY POSSESSION. I ALSO UNDERSTAND THAT ANY VALUABLES SHOULD BE SENT HOME WITH A FAMILY MEMBER OR IF VISITING MAIN FACILITY, LOCKED IN THE HOSPITAL SAFE.

PATIENT RIGHTS AND RESPONSIBILITIES: I HAVE BEEN INFORMED THAT I HAVE CERTAIN RIGHTS AND RESPONSIBILITIES AS A PATIENT A POSTED COPY IS AVAILABLE TO ME AT THIS TIME. I HAVE BEEN OFFERED AND RECEIVED A COPY AS I DESIRED AND AM AWARE THAT I WILL HAVE A COPY IN MY PATIENT INFORMATION PACKET IF I AM ADMITTED.

* _____ **RELEASE OF INFORMATION:** I AUTHORIZE THE FACILITY TO RELEASE INFORMATION TO MY PHYSICIAN(S) AND TO ANY THIRD-PARTY PAYOR ("PAYOR") INCLUDING BUT NOT LIMITED TO MEDICARE, TENNCARE, MY PERSONAL INSURANCE COMPANY, CHAMPUS/CHAMPVA, WHEN NECESSARY TO PROCESS MY CLAIM AND DISTINGUISH NEED FOR FURTHER CARE. I UNDERSTAND THAT I MAY OBTAIN A COPY OF MY MEDICAL RECORDS FROM FACILITY'S HEALTH INFORMATION MANAGEMENT DEPARTMENT AFTER SIGNING A WRITTEN REQUEST AND PAYING THE REQUIRED FEES. I UNDERSTAND REQUIRED INFORMATION WILL BE DISCLOSED IF I AM DIAGNOSED WITH A CONDITION THAT BY LAW REQUIRES REPORTING A HEALTH DEPARTMENT OR THE CENTER FOR DISEASE CONTROL AND PREVENTION.

WORKERS COMPENSATION: THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. SECTION - AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

Employer: _____ Phone: _____

* _____ **INDEPENDENT PHYSICIANS/PRACTITIONERS:** I UNDERSTAND DURING MY CARE I MAY BE TREATED BY INDEPENDENT HEALTHCARE PROVIDERS, WHO WILL BILL ME INDEPENDENTLY FOR THEIR CHARGES AS ESTABLISHED BY SUCH PROVIDERS. I AGREE THAT FACILITY IS NOT RESPONSIBLE FOR, NOR DOES FACILITY ASSUME ANY LIABILITY FOR THE ACTIVITIES OF SUCH HEALTH CARE PROVIDER OR ANY OTHER SUPPLIER OF CARE SERVICE WHO IS NOT AN EMPLOYEE OF THE FACILITY.

* **PATIENT PORTAL:** BLOUNT MEMORIAL HOSPITAL OFFERS A PATIENT PORTAL WHICH ALLOWS A PATIENT (OR DESIGNEE) TO SET UP A SECURE USERNAME AND PASSWORD TO ACCESS THEIR MEDICAL RECORDS THREE DAYS AFTER DISCHARGE. IF YOU WISH TO PARTICIPATE YOU MUST PROVIDE AN EMAIL ADDRESS. BY SUPPLYING THE EMAIL ADDRESS AT THE TIME OF REGISTRATION, I ACKNOWLEDGE THAT MY MEDICAL INFORMATION WILL BE ABLE TO BE ACCESSED THROUGH PATIENT PORTAL AFTER I (OR WHO I ALLOW ACCESS TO MY EMAIL) RESPOND TO THE INVITATION TO PARTICIPATE IN PATIENT PORTAL AND CREATE MY OWN UNIQUE PASSWORD. I ALSO ACKNOWLEDGE THAT I AM RESPONSIBLE FOR WHOM I ALLOW ACCESS TO THIS INFORMATION.

Email Address: _____ Owner Name: _____

* **MEDICATION AND MEDICAL DEVICE ASSISTANCE PROGRAM:** IN SOME CASES, THE HOSPITAL MAY BE ABLE TO OBTAIN REIMBURSEMENT FOR SOME OF YOUR MEDICATIONS OR MEDICAL DEVICES FROM COMPANIES THAT MANUFACTURE THEM. IN THE EVENT THIS OCCURS, THE CHARGE FOR THE MEDICATION OR MEDICAL DEVICE IS REMOVED FROM YOUR BILL FOR THAT HOSPITAL STAY. MOST OF THESE PROGRAMS REQUIRE YOUR SIGNATURE ON THE APPLICATIONS FORMS. IN ORDER TO AVOID YOU HAVING TO SIGN THIS APPLICATION FOR EACH MEDICATION OR DEVICE, WE ARE REQUESTING THAT YOU ALLOW A PHARMACY HEALTHCARE SOLUTIONS (PHS) REPRESENTATIVE TO SIGN THESE FORMS ON YOUR BEHALF. I APPOINT PHS TO CARRY OUT IN MY NAME, THE APPLICATION FORMS REQUIRED FOR PHS TO OBTAIN REPLACEMENT OF MY MEDICATIONS OR MEDICAL DEVICES FROM MANUFACTURERS. THE BELOW SIGNATURE WILL BE ACTIVE FROM DATE SIGNED.

[ ] I DO NOT WISH TO PARTICIPATE

* **PHOTO IDENTIFICATION REQUIREMENT:** WE REQUEST A PHOTO OF YOU USED SOLELY FOR IDENTIFICATION PURPOSES. YOUR PICTURE WILL NOT BE DISCLOSED WITH MEDICAL RECORDS RELEASE WITHOUT YOUR CONSENT. IF YOU CANNOT PROVIDE PHOTO IDENTIFICATION, SUCH AS DRIVER'S LICENSE, WE WILL MAKE A DIGITAL PHOTO.

[ ] NO, I DO NOT AGREE TO HAVE MY PHOTO TAKEN FOR IDENTIFICATION.

---------- **HOSPITAL ONLY** ----------

* **INFORMATION / SWITCHBOARD CENSUS NOTIFICATIONS:**

I UNDERSTAND THAT MY NAME AND LOCATION MAY BE INCLUDED IN BMH'S PATIENT DIRECTORY. INFORMATION FROM THE DIRECTORY MAY BE SHARED WITH PEOPLE WHO ASK FOR ME BY NAME.

[ ] NO, DO NOT LIST ME IN THE PATIENT DIRECTORY. IF I GIVE OUT MY LOCATION AND NUMBER I UNDERSTAND THESE VISITS AND CALLS CAN NOT BE RE-ROUTED

I CERTIFY THAT I UNDERSTAND THIS CONSENT/RELEASE FORM AND AGREE TO ITS TERMS.

SIGNED: _____ **WITNESS:** _____

BY: _____ **DATE/TIME:** _____

RELATIONSHIP TO PATIENT: _____

About Your Jackson-Pratt Drainage System

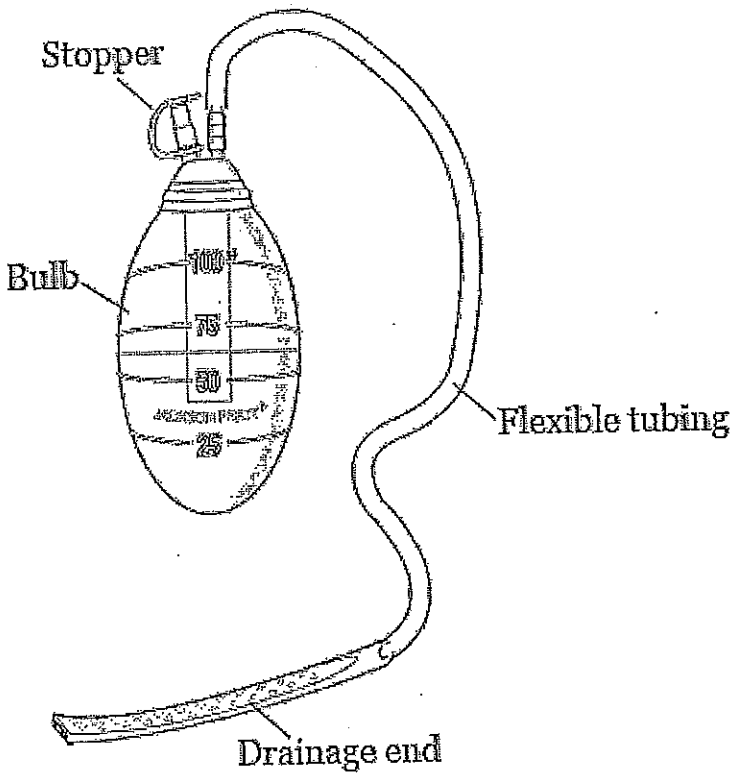

Figure 1. Jackson-Pratt drain

The Jackson Pratt drainage system (JP drain) draws out fluid that collects under your incision (surgical cut) after your surgery.

It has a soft plastic bulb with a stopper and flexible tubing attached (see Figure 1). The drainage end of the tubing (flat white portion) is placed into your surgical site through a small opening near your incision. This area is called the insertion site. A suture (stitch) will hold it in place. The rest of the tube will extend outside your body and will be attached to the bulb.

When the bulb is compressed (squeezed) with the stopper in place, a constant gentle suction is created. The bulb should be compressed at all times, except when you are emptying the drainage.

How long you will have your Jackson-Pratt depends on your surgery and the amount of drainage you're having. Everyone's drainage is different. Some people drain a lot, some only a little. The Jackson-Pratt is usually removed when the drainage is 30 mL or less over 24 hours. You will record the amount of drainage in the drainage log. It's important to bring the log with you to your follow-up appointments.

Caring for Your Jackson-Pratt at Home

Caring for your Jackson-Pratt at home will involve the following:

- Milking the tubing to help move clots.
- Emptying the drain 2 times a day and recording the amount of drainage on the Jackson-Pratt Drainage Record.
    - If you have more than 1 drain, make sure to measure and record the drainage of each one separately. Do not add them together.
- Caring for your insertion site.
- Recognizing when there is a problem.

Milking the tubing

These steps will help you move clots through the tubing and keep the drainage flowing.

Milk the tubing before you open the stopper to empty and measure your drainage. You should also do this if you see fluid leaking around the insertion site.

1. Clean your hands. To wash your hands with soap and water, wet your hands, apply soap, rub them together thoroughly for 15 seconds, then rinse. Dry your hands with a disposable towel, and use that same towel to turn off the faucet. If you're using an alcohol-based hand sanitizer, cover all of your hands with it, rubbing them together until they're dry.
2. Look in the mirror at the tubing. This will help you see where your hands need to be.
3. Pinch the tubing close to where it goes into your skin between the thumb and forefinger of your hand. This will help to make sure that you're not tugging on your skin, which can be painful.
4. With the thumb and forefinger of your other hand, pinch the tubing right below your other fingers. Keeping your fingers pinched; slide them down the tubing, pushing any clots down toward the drainage bulb. You may want to use alcohol wipes to help you slide your fingers down the tubing.
5. Repeat steps 3 and 4 as necessary to push clots from the tubing into the bulb. If you are not able to move a clot into the bulb and there is little or no drainage in the bulb, call your doctor or nurse.

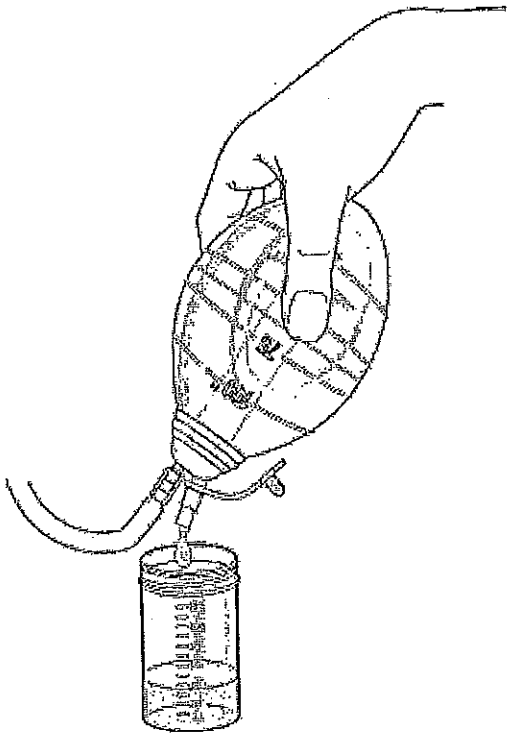

Figure 2: Emptying the bulb

Emptying your Jackson-Pratt drain and recording the drainage

You will need to empty your Jackson-Pratt in the morning and in the evening.

Supplies

- Measuring container your nurse gave you
- Jackson-Pratt Drainage Record
- Pen or pencil

Instructions

1. Prepare a clean area to work on and gather your supplies. This can be done in your bathroom or in an area with a dry, uncluttered surface.
2. Clean your hands. To wash your hands with soap and water, wet your hands, apply soap, rub them together thoroughly for 15 seconds, then rinse. Dry your hands with a disposable towel, and use that same towel to turn off the faucet. If you're using an alcohol-based hand sanitizer, cover all of your hands with it, rubbing them together until they're dry.
3. If the drainage bulb is attached to your surgical bra or wrap, first remove it from there.
4. Unplug the stopper on top of the bulb. This will cause the bulb to expand. Do not touch the inside of the stopper or the inner area of the opening on the bulb.
5. Turn the bulb upside down, gently squeeze the bulb, and pour the drainage into the measuring container (see Figure 2).
6. Turn your bulb right side up.

7. Squeeze the bulb until your fingers feel the palm of your hand.
8. Continue to squeeze the bulb while you replug the stopper.
9. Check to see that the bulb stays fully compressed to ensure a constant gentle suction.
10. Do not let the drain dangle.
    - If you are wearing a surgical bra, there will be either a plastic loop or Velcro® straps attached at the bottom. Attach the drainage bulb to the bra.
    - If you are wearing a wrap, attach the drainage bulb to the wrap.
    - A fanny pack or belt bag may be helpful to hold the drain.
11. Check the amount and color of drainage in the measuring container. The first couple of days after surgery, the fluid may be dark red in color. This is normal. As you continue to heal it may appear pink or pale yellow.
12. Record this amount and the color of drainage on your Jackson-Pratt Drainage Record.
13. Flush the drainage down the toilet and rinse the measuring container with water.
14. At the end of each day, add up the total amount of drainage for the 24-hour period and record it in the last column of the drainage record. If you have more than 1 drain, measure and record each one separately.

Caring for the Insertion Site

Once you have emptied the drainage, clean your hands again. Check the area around the insertion site. Look for tenderness, swelling, or pus from the insertion site. If you have any of these, or if you have a temperature of 101° F (38.3° C) or higher, you may have an infection. Call your doctor's office.

Sometimes the drain causes redness about the size of a dime at your insertion site. This is normal. Your healthcare provider will tell you if you should place a bandage over the insertion site.

Keep your insertion site clean and dry by washing it with soap and water and then gently patting it dry.

Problems You May Have With Your Jackson-Pratt

Problem

- The bulb is not compressed.

Reason

- The bulb wasn't squeezed tightly enough.
- The stopper is not closed securely.
- The tubing has been dislodged and is leaking.

What to do

- Compress the bulb using steps 2 through 9, outlined in "Emptying your Jackson-Pratt drain and recording the drainage."
- If the bulb remains expanded after following the steps above, call your doctor or nurse during business hours.

Problem

There is:

- No drainage.
- A sudden decrease in the amount of drainage.
- Drainage around the tubing insertion site or on the bandage covering the tubing.

Reason

- Sometimes string-like clots clump together in the tubing. This can block the flow of drainage.

What to do

- Milk the tubing as described above.
- If there is no increase in drainage flow, call your doctor's office during business hours. If it occurs after business hours, call the next day.

Problem

- The tubing falls out of your insertion site.

Reason

- This can happen if the tubing is pulled. It rarely happens because the tubing is held in place with sutures.

What to do

- Place a new bandage over the site and call your doctor's office during business hours.

Problem	Reason
• You have redness greater than the size of a dime, swelling, heat, or pus around your insertion site.	• These may be signs of an infection. What to do • Take your temperature. Call your doctor or nurse and describe the signs of infection around your insertion site. Let them know if your temperature is 101° F (38.3° C) or higher.

Once you know how to care for your Jackson-Pratt, you will do it on your own. Your nurse will watch you the first time you empty the drainage to make sure you are doing it correctly. Even after you have begun to care for it yourself, you can always ask for help. If you have any problems while you're at home, call your doctor's office.

Call your doctor or nurse right away if you have:

- Bright red drainage
- A temperature of 101° F (38.3° C) or higher
- Increased redness, tenderness, swelling, or pus at your insertion site

Call your doctor or nurse during business hours if:

- The amount of drainage suddenly drops or has increased 100 mL over the past 24 hours
- The tube falls out of the insertion site
- You cannot compress the bulb

Caring for Your Skin After Your Drain Is Removed

Your drain will be removed at your doctor's office. You will have a bandage over the insertion site.

It is important for you to keep your insertion site and the area around it clean and dry. This will help to prevent infection and promote healing of your skin. Caring for your skin after your drain is removed will be different if you had reconstructive surgery.