WASATCH ENDOCRINOLOGY and DIABETES SPECIALISTS
INITIAL ENCOUNTER NOTE Page 1 Date: __/__/_____

Consult requested by: _____ || New Patient

Reason for this visit: [Counseling Only]_____

_____

Data reviewed [None provided] _____

_____

Issues/Hx _____

Pt ID Here

SIGNIFICANT ADDITIONAL HISTORY

Social/Occ Hx: _____

Current Meds: [As Noted] _____

Allergies/Intolerances: {As Noted] _____

PMH: [As Noted] _____

Health Inventory: [As Noted] _____

FH: [As Noted] _____

ROS: [As Noted] _____

EXAM/LAB:

VS/Lab: Ht: ___ Wt: _____ || BMI: _____ || P: ____ BP: ____/ _____ || A1c: ____

Appearance: _____

HEN/OP: _____ E/O: _____

Thyroid: _____

Resp: _____ Cor: _____

Abd: _____ Hep: _____ Spl: _____

Spine: _____ CVA/Lumbar: _____

DTR[R/L] B:____/____ Pat: ____/____ A: ____/____ Neuro: _____

Art [R/L] _____ Venous: _____

INITIAL ENCOUNTER NOTE Page 3 Additional Pages? No Yes #_____

U/Ext: _____ LExt: _____

Hands: _____

Feet: _____

Skin: _____ Hair: _____

Breasts: _____ Gen: _____

Other Findings: _____

Assessment/DX:

C/E: _____

PLAN/ ORDERS:

RX: _____

LAB/STUDIES: _____

F/U: _____

OTHER: _____

Patient ID HERE

Duration: C/E >50%

S: _____ Robert E Burr MD FACP FACE

Billed ____ / _____ / _____ 99203 99204 99205 99354 99355 by _____

WASATCH ENDOCRINOLOGY and DIABETES SPECIALISTS
FOLLOW-UP ENCOUNTER NOTE Page 1 Date: ___/___/_____

LV: ____/____/_____ Reason for this visit: _____

New data reviewed: Labs SBGM BP CT/MRI Other: _____

Current Meds (Name/Dose/Frequency)

_____

_____

_____

_____

_____

Any New Issues? No Yes: _____

_____

_____

Interval History: S/O Hx: No Change | PMHx: No Change | Health Inventory: No Change | FHx: No Change

_____

_____

_____

ROS: No Change _____

_____

_____

VS/Lab: Ht: ___ Wt: ____|| BMI: ____ Change: ____ || P: ____ BP: ___/___ || A1c: ____ Change: _____

Issues/Evolution (SOAC):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLAN/ORDERS:

LABS/STUDIES: _____

RX: _____

FOLLOW_UP: _____

OTHER NOTES: _____

Patient ID: Additional Pages? No Yes: # __ Duration: C/E>50%

DOB: ___ /____ /____ S: _____ Robert E Burr MD FACP FACE

Billed ____ / _____ / _____ 99213 99214 99215 99354 99355 by _____

Wasatch Endocrinology and Diabetes Specialists
807 East South Temple, Suite 101
Salt Lake City, UT 84102
Phone 801-746-0776 Fax 801-746-0775

Order Requisition Form

Monday October 26, 2009

PATIENT INFORMATION

Name:
DOB:
Address
Phone:

INSURANCE INFORMATION

Primary

Secondary

DIAGNOSES (ICD)

ORDERING PROVIDER

Robert E. Burr MD, FACE, FACP
(electronic signature)

REQUESTED STUDIES

Hospital/Provider: Please fax completed report to (801) 746-0775

*Please call your insurance company to verify coverage PRIOR to your scheduled appt/procedure. The only way for you as a patient to be sure is to contact them directly. Wasatch Endocrinology is not liable for non-covered services. We will be happy to reschedule or suggest an alternative.

Location: **Phone:**

Date: Time:

Dear Patient,

WASATCH
ENDOCRINOLOGY

Thank you for choosing Wasatch Endocrinology
& Diabetes Specialists for your healthcare needs.

We work very hard to keep our schedule on time, so we appreciate your being here 15 minutes prior to your appointment for check-in. **Please notify the office 24 hours in advance if you are unable to keep your appointment.** Please call our office to confirm by noon the day before your scheduled appointment otherwise it will be cancelled.

Have this packet completely filled out when you come in for your appointment, otherwise we will have to reschedule. This will help expedite your visit and allow us to use your appointment time in the best way.

On the day of your appointment, please bring the following items with you:

1. Insurance card(s) & Picture ID
2. Co-payment (cash, check or credit/debit cards)
3. This completed packet
4. Any additional medical records, reports, x-rays, or scans
5. Any medicines/ supplements you take (actual medications are better than a list)
6. If you have diabetes, bring your meter and any written records of your blood sugar levels

****If you must bring your children with you, please bring someone to look after them, keep in mind that you may be here for up to 2 hours****

Insurance questions should be directed to your insurance company or to our billing office at (801) 619-2159 or (866) 553-9568. The office staff does not have the information needed to address these issues. We may accept your insurance but *please call your insurance company to verify coverage* prior to your appointment. Wasatch Endocrinology is not liable for non-covered services.

We look forward to seeing you and hope you'll find your visit with us helpful. If you have any other questions please feel free to contact us.

Thank You!

No Show and Same Day Cancellation Policy

Your appointment time is reserved **exclusively** for you. We ask that you please be considerate of others— if you miss your appointment or cancel at the last minute, we will be unable to care for another patient in your place.

Please call 24 hours in advance to avoid fees.

Each no-show case will be evaluated. There may be extenuating circumstances which can be taken into account. Forgetting is never an extenuating circumstance.

New patient- No Show: We will not reschedule

- If appointment is no showed, we will refer you back to your previous provider

New patient- Same Day Cancellation: Due to the high volume of New Patients wanting to be seen we will reschedule only ONCE.

- With proper 24 hour notice we will only reschedule a maximum of TWO times.

Established Patient- No Show: We will excuse the no-show only ONE time

- After the second no-show the patient will be sent an appointment warning letter and charged a missed appointment fee. Fee will need to be paid PRIOR to scheduling another appointment
    - $50 fee for an appointment 30 minutes
    - $100 fee for an appointment 1 hour or more
- Additional no-show, the patient will receive a termination letter

Established Patient- Same Day Cancellation**:** We will excuse the cancellation only ONE time.

- After the second same-day cancellation the patient will be sent an appointment warning letter and charged a missed appointment fee. Fee will need to be paid PRIOR to scheduling another appointment.
    - $50 fee for an appointment 30 minutes
    - $100 fee for an appointment 1 hour or more
- Additional same-day cancellation, the patient will receive a termination letter

Please print, sign and date to acknowledge that you have read the policy.

Print:_____

Signature: _____ **Date:** _____

Smile Reminder

Our new reminder system, Smile Reminder, allows us to send you information and reminders by e-mail and text messages to your cell phone or PDA.

Please fill out the contact information:

Cell phone: _____

E-Mail: _____

☐ Check if you would not like to receive e-mails or text messages.

Please let us know the reason: (optional)

_____

_____

_____

☐ Check if you do not have an e-mail or cannot receive text messages.
(You can always register at a later time.)

Insurance Information

(Required)

Primary Insurance:_____

Policy/ID#:_____Group#:_____

Insured Name:_____ Date of Birth:____/____/_____

Insured Social Security #:_____-_____-_____

Secondary Insurance:_____

Policy/ID#:_____Group#:_____

Insured Name:_____ Date of Birth:____/____/_____

Insured Social Security #:_____-_____-_____

Primary Care Provider

Name: (Required if applicable)	Referrer? Yes No
Office Address:	Records request? Yes No
City/ State/ Zip:	
Office Phone: (Required if applicable)	Office Fax:
What are you seeing them for?	
Do you want us to send them a report? Yes No	

Other Health Care providers you see

Name: (Required if applicable)	Referrer? Yes No
Office Address:	Records request? Yes No
City/ State/ Zip:	
Office Phone: (Required if applicable)	Office Fax:
What are you seeing them for?	
Do you want us to send them a report? Yes No	

Name: (Required if applicable)	Referrer? Yes No
Office Address:	Records request? Yes No
City/ State/ Zip:	
Office Phone: (Required if applicable)	Office Fax:
What are you seeing them for?	
Do you want us to send them a report? Yes No	

Preferred Pharmacy

Name: (Required)	
Address:	
City/ State/ Zip:	
Phone #: (Required)	Fax #:

What can we help with?

_____
_____
_____
_____

Occupation:_____

Any past occupational exposures or injuries?_____

Are you disabled? No Yes Since:_____

Why?_____

Preventive Health Practice Inventory (Please circle your answer)

Influenza Vaccination: Current / Not recently / Never Pneumovax: Yes / Never

Last Checkup? In the last year / In the last 5 years / Long time ago

Preventive checks (cholesterol, blood pressure): Y / N

Cancer screenings (mammogram, colonoscopy): Y / N

Tobacco History: None / ½ PPD / 1PPD / >1PPD / Past user, quit in _____

Alcohol Intake History: None / <2 month / >6 month / Daily

Exercise: None / 1-2 days per week / 3-4 days per week / More

Nutritional aids or supplements: Calcium / Vitamins / Ergogenic aids / Weight loss aids

Others: _____

MEDICATION & SAFETY INVENTORY

CURRENT MEDICATIONS

(Please include non-prescription medications and supplements, attach additional sheet if necessary.)

Medication	Strength	Amount	When	Why	From

ALLERGIES and INTOLERANCES

Medication and Other Allergies

To What	What happens/happened?

Intolerances-are there other medications or foods you can't take for any reason?

_____

_____

_____

Health Inventory

Past History (Most recent first please)

Medical Conditions	When Diagnosed?	Is this still a problem?
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No

Past Surgical History

Procedure:	When?	Where?	Why?

Hospital Stays

For What?	When?	Where?

Family Medical History Checklist

	Don't Know	Living (L) Deceased (D)	Age	Healthy		Diabetes	Thyroid	Osteoporosis	High Cholesterol	High Blood Pressure	Heart Disease	Kidney Disease	Stroke	Alzheimer's Disease	Depression	Cancer	Other	Other _____
Parents																		
Mother																		
Father																		
Grandparents																		
Mother's mother																		
Mother's father																		
Father's mother																		
Father's father																		
Siblings																		
Other Family																		

Are there any other conditions that seem to run in your family or about which you are particularly concerned?

_____

_____

_____

_____

_____

_____

Comprehensive Symptom and Functional Review Checklist

General Health (Circle One)

General state of health	Excellent	Good	Moderate	Fair	Poor
Sense of well-being	Excellent	Good	Moderate	Fair	Poor
How is your energy level?	Excellent	Good	Moderate	Fair	Poor
How is your appetite?	Excellent	Good	Moderate	Fair	Poor
Ability to conduct usual activities	Excellent	Good	Moderate	Fair	Poor
What activities are most difficult?					
Are you strong enough to do what you need to do?	Yes, always	Mostly	Sometimes	Not at all	
What's the most strenuous exercise you can do?					

Nutrition and Diet

What is your usual weight?		What do you think you weigh now?			
What's the most you remember weighing?			When was that?		
Are you gaining or losing weight?	Gaining a lot	Gaining a little	Steady	Losing a little	Losing a lot
If your weight is changing, is it deliberate?	Yes	No			

Skin, hair and nails (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have a skin rash?				
Does your skin itch?				
Has your skin gained or lost pigmentation?				
Is your skin excessively sweaty or dry?				
Has the texture of your skin changed?				
Are you losing hair?				
Are you having new or bothersome hair growth?				
Do you have any changes in your nails?				

Breasts (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Have you noticed breast lumps?				
Have you noticed any breast tenderness?				
Have you noticed any breast discharge?				
Have you noticed any breast swelling?				

Nervous system (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have headaches?				
Have your headaches changed recently?				
Do you have dizziness or lightheadedness?				
Have you even had a head injury with loss of consciousness or concussion?				
Do you have trouble with coordination or balance?				
Do you have a trouble with standing up or reaching overhead?				
Do you have numbness or tingling anywhere?				

Vision (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you wear glasses or contacts?				
Do you have any double vision?				
Do you have any blind spots or trouble seeing to one side or another?				
Do you have pain or redness in your eyes?				
Have you ever had eye surgery?				

Hearing (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have any trouble with your hearing?				
Do you have any trouble perceiving speech clearly?				
Do you have ringing of pain in your ears?				

Nose and sinuses (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have nasal obstruction?				
Do you have frequent colds or sinus infections?				
Do you have nose bleeds?				

Mouth and teeth (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have any bleeding from brushing?				
Do you have any dental pain with eating or cold liquids?				

Neck and throat (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have any difficulty with swallowing?				
Do you have any pain in your throat or neck?				
Do you have any lumps in your neck or throat area?				
Has your voice changed or become hoarse?				

Heart and Vascular (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have chest pain or pressure?				
Does your heart skip beats or seem to beat too fast?				
Do you have fainting spells?				
Do you get short of breath with ordinary exertion?				
Do you get short of breath at night or when you lie down?				
Do you get swelling in your legs or ankles?				
Do you get pain in your legs when you walk?				

Respiratory (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have pain when you breathe?				
Do you have wheezing or asthma?				
Do you have a cough?				
Do you ever cough up blood?				
Do you have frequent colds or bronchitis?				
Do you snore enough to disturb you or others?				

Gastrointestinal (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have pain when you swallow?				
Does food ever get stuck when you swallow?				
Do you have heartburn or trouble keeping your food down?				
Do you get stomach pain or nausea before or after you eat?				
Do you have trouble with vomiting?				
Do you have trouble with constipation or diarrhea?				
Are your bowels movements abnormal in any way?				

Kidneys and bladder function (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have trouble with kidney or bladder infections?				
Do you have trouble starting urination or emptying your bladder?				
Do you have trouble holding urine?				
Do you have trouble with painful urination?				
Do you wake up during the night to urinate?				
Do you have to urinate frequently?				

Reproductive – Women Only (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
When did you first start your period?				
Date of last menstrual period?				
Have your periods stopped?				
Are/were your periods irregular?				
Have you ever had a miscarriage?				
Have you ever had difficulty becoming pregnant?				
Have you ever delivered a baby weighing more than 9 pounds?				
Do you have a decreased interest in sex?				

Reproductive – Men Only (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have difficulty having an erection?				
Do you have difficulty maintaining an erection?				
Do you have decreased interest in sex?				

Musculoskeletal (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have unusual pain in any joints or muscles?				
Do you get muscle cramps?				
Do your joints swell?				

Psychological (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you get depressed enough to affect your daily life				
Do you get anxious enough to affect your daily life?				

Blood and Lymph Systems (check applicable box)

	Never	A long time ago, but not now	In the last year or so	This is a problem now
Do you have anemia?				
Do you have any enlarged lymph nodes?				
Do you have a tendency to bruise or bleed?				

Patients with Diabetes Only

What was your last glycohemoglobin? _____

When was your last eye examination? _____

When was your last foot examination? _____

Can you tell if your blood sugar is low? Yes / No

What happens when your blood sugar is low? _____

How often are you checking your blood sugar?

I don't test. Once a day 2-4 times a day 4-8 times a day More than 8 times a day

How often do you have a low blood sugar reaction?

Never Once a month 2-3 times a month Once a week More than once a week Daily

Have you ever been hospitalized for low or high blood sugar?

No / Yes More than once? No /Yes When? _____

Do you have any complications of your diabetes?

Eyes: No / Yes Have you ever needed laser treatment? No / Yes

Feet and nerves: Do you have: No symptoms Numbness Tingling Pain

Kidneys: No / Yes When was the last time you had your urine protein checked?

If this is not completed BEFORE your scheduled appointment we may have to reschedule.

Thank You for your time & being prepared.