Sparrow
Herbert-Herman
Cancer Center

Phone: 517.364.9402
Fax: 517.487.3148 or 517.364.9449
After Hours/On Call: 517.364.1000

Medical Oncology

The caregivers in the Medical Oncology Outpatient department are dedicated to delivering the highest quality, compassionate and most cost-effective health services possible. To that end, our caregivers will act in a leadership role to ensure a comprehensive continuum of services and will coordinate the education, prevention, diagnoses, treatment, and follow-up/home care aspects of patient care. We are dedicated to high quality care and will accomplish the preceding mission through living their values of Excellence, Service, Responsibility, Innovation, and Teamwork.

As our patient, please remember:

Office Hours:

Monday-Thursday	8:00 a.m. until 12:00 p.m. and 1:00 p.m. until 4:30 p.m.
Friday	8:00 a.m. until 12:00 p.m. and 1:00 p.m. until 4:00 p.m.

*closed on weekends and all major holidays

For after-hour concerns, call 517.364.1000 and ask for the Sparrow Cancer Center on-call physician to be paged. One of our physicians will call you back. Should you have an emergency, please call 911 or go directly to the emergency room.

General Reminders:

- Please bring any outside scans (on a disk) with you to your first appointment so your oncologist may review them.
- Please understand that the provider schedules do not allow consults with patients on a drop-in basis. This disrupts the process of caring for those patients with scheduled appointments. If you have a concern, please expect to leave a message. We will do everything possible to help, but if it is an emergency, you will be sent to the emergency room.
- All non-oncology/hematology issues must be addressed with your primary care physician; such as injuries, colds or Medications that they have prescribed.

Prescriptions:

- Refills: You may call in to renew only those prescriptions that your oncologist/hematologist has ordered for you. Refills will be called in within 48 hours from your request.
- Pain Medications: Prescriptions for pain medications will need to be picked up at the office. Please remember that it may take 48 hours to process your request for a refill; plan ahead for weekends, holidays, etc.

Forms:

Any disability, leave of absence, medical necessity letters, or medical records may take up to two weeks to complete. Please be sure to allow time when requesting these. You are responsible for all costs associated with processing such paperwork.

Treatments:

- All patients undergoing treatment need to have their lab work completed a minimum of 2 days prior to the scheduled treatment date. Failure to do so may result in treatment delay or cancellation.
- It is the patient's responsibility to schedule treatment times and physician appointments. Should you arrive without a scheduled appointment you may be asked to come back at another time based on provider availability.
- We expect to hear from you prior to your chemotherapy appointment if you are experiencing a problem. Side effects from chemotherapy should be reported promptly to our caregivers so we may provide you with the best possible care.

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Patient Appointments

It is important for patients to be on time for scheduled appointments and to contact the Medical Oncology & Infusion Office if an appointment needs to be rescheduled or cancelled. Late arrivals or appointments in which the patient is a no-show can affect physician availability, delay other patient appointments, and create limited space within the clinic and treatment areas.

Patient appointments can be scheduled, rescheduled, or cancelled by calling the Medical Oncology & Infusion Office at **(517) 364-9402.**

Late Arrivals for Appointments:

Please arrive at least 15 minutes prior to your appointment time. If you arrive past the scheduled appointment time, the front office team will contact the clinic nurse who will communicate to the physician to make every attempt to proceed with the scheduled appointment, but this is not a guarantee. If you arrive past your scheduled appointment time your appointment may be cancelled and will need to be rescheduled.

No-Show Policy:

The No-Show Policy is intended to prevent appointments in Medical Oncology and Infusion from going unused due to patients not arriving for their scheduled appointment times. The patient is responsible for keeping their scheduled appointment and for notifying the office within 24 hours if they are unable to keep the appointment.

A No-Show is defined as an appointment that has been made and the person scheduled for the appointment does not cancel or keep the allotted appointment. After a patient has 3 no-shows, the patient will be contacted and a letter will be sent notifying that no further appointments will be scheduled at the Cancer Center.

1140 E. Michigan Avenue
Lansing, Michigan 48912

T 517.364.9400
T 1.800.SPARROW
sparrow.org

Sparrow
Herbert-Herman Cancer Center

Patient Information

NAME: _____
First Middle Last

ADDRESS: _____

CITY:_____ **STATE**_____ **ZIP**_____

BIRTHDATE:____/_____/_____ **SOCIAL SECURITY #:**_____ **MARITAL STATUS: S M W**

HOME PHONE #: (_____**)**_____ **ALTERNATE PHONE #: (**__**)** _____

EMPLOYER: _____

INSURANCE: (PRIMARY)_____ **(SECONDARY)** _____

GUARANTOR NAME:_____ **DOB:**__/_____/_____

SPOUSE NAME:_____ **SPOUSES BIRTHDATE:**___/_____/_____

SPOUSE'S SOCIAL SECURITY #:_____ **SPOUSE'S EMPLOYER:**_____

FAMILY PHYSCIAN: _____

ADDRESS:_____ **PHONE NUMBER: (**____**)** _____

May we please have the name and number of another person we may contact if we are having trouble getting a hold of you? We need a contact person who would be able to relay a message to you promptly.

NAME:_____ **PHONE NUMBER :(**_____**)**_____

RELATIONSHIP: _____

ALL PATIENTS MUST ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. **Is the patient eligible for Black Lung benefits?** **YES** **NO**
2. **Are patient's services paid by government research program?** **YES** **NO**
3. **DVA (Dept. of Affairs) authorized and agreed?** **YES** **NO**

PATIENT SIGNATURE:_____ **DATE:** _____

Sparrow
Herbert-Herman Cancer Center

Date_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of medical record

Name (Last, First, M.I.): _____

□ M □ F DOB:_____/_____/_____Marital status: □ Single □ Married □ Separated □ Divorced □ Widowed

Religion (Optional):_____Nationality (Optional): _____

Primary Language:_____ Interpreter Needed: □ Yes □ No

Prefer to receive instructions: Written Verbal Visual

Primary Care Doctor:_____Referred doctor: _____

Level of education: Grade_____High School_____College/University_____Post graduate degree_____

Advance Directive: Yes No Information

requested/provided Domestic Violence Assessment: within the last

year did you experience:

Physical Abuse_____Emotional Abuse_____Sexual Abuse_____ Please list the reason for this visit or health concerns you have.

_____

PAST MEDICAL HISTORY

List any medical problems that other doctors have diagnosed. In the space list the date diagnosed and any additional information.

Cancer	□ Yes □ No _____	Gallstones	□ Yes □ No _____
Chemotherapy	□ Yes □ No _____	Reflux	□ Yes □ No _____
Hormonal therapy	□ Yes □ No _____	Jaundice/Hepatitis	□ Yes □ No _____
Radiation therapy	□ Yes □ No _____	Pancreatitis	□ Yes □ No _____
Blood transfusion	□ Yes □ No _____	Rectal Polyps	□ Yes □ No _____
Diabetes	□ Yes □ No _____	Ulcers	□ Yes □ No _____
Gout	□ Yes □ No _____	Ulcerative Colitis	□ Yes □ No _____
Thyroid condition	□ Yes □ No _____	Bladder Infections	□ Yes □ No _____
Cataracts	□ Yes □ No _____	Blood in Urine	□ Yes □ No _____
Glaucoma	□ Yes □ No _____	Kidney Failure	□ Yes □ No _____
Sinus Problems	□ Yes □ No _____	Kidney Stones	□ Yes □ No _____
Angina	□ Yes □ No _____	Epilepsy	□ Yes □ No _____
Edema	□ Yes □ No _____	Migraines	□ Yes □ No _____
Heart Attack (MI)	□ Yes □ No _____	Stroke	□ Yes □ No _____
Heart Failure	□ Yes □ No _____	Anemia	□ Yes □ No _____
Heart Murmur	□ Yes □ No _____	Blood Clots	□ Yes □ No _____
High Blood Pressure	□ Yes □ No _____	Bleeding Tendency	□ Yes □ No _____
Irregular Heartbeat	□ Yes □ No _____	Other Blood Disorder	□ Yes □ No _____
Rheumatic Fever	□ Yes □ No _____	HIV positive (AIDS)	□ Yes □ No _____
Asthma	□ Yes □ No _____	Chronic Infection	□ Yes □ No _____
Chronic Bronchitis	□ Yes □ No _____	Arthritis	□ Yes □ No _____
Emphysema	□ Yes □ No _____	Collagen Vascular Disease	□ Yes □ No _____
Pneumonia	□ Yes □ No _____	Fibromyalgia	□ Yes □ No _____
Tuberculosis	□ Yes □ No _____	Lupus	□ Yes □ No _____
Cirrhosis of the Liver	□ Yes □ No _____	Osteoporosis	□ Yes □ No _____
Crohn's Disease	□ Yes □ No _____	Anxiety/Panic	□ Yes □ No _____
Diverticulosis/Diverticulitis	□ Yes □ No _____	Depression	□ Yes □ No _____
Hernia	□ Yes □ No _____	Eating Disorder	□ Yes □ No _____
Intestinal bleeding	□ Yes □ No _____	Other	□ Yes □ No _____
Irritable Bowel Disease	□ Yes □ No	Other	□ Yes □ No

PAST SURGERIES

YEAR	HOSPITAL	REASON FOR SURGERY

PAST HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had

MEDICATIONS

List your prescribed drugs, over-the-counter drugs and vitamins

MEDICATION	STRENGTH OR DOSE	FREQUENCY

NAME OF PRIMARY PHARMACY:

PHONE:

NAME OF MAIL ORDER PHARMACY:

PHONE:

NAME OF SPECIALTY PHARMACY:

PHONE:

Constitution

Yes		No	Activity Change
Yes		No	Appetite Change (↑/↓)
Yes		No	Chills
Yes		No	Diaphoresis (Sweating)
Yes		No	Fatigue
Yes		No	Fever
Yes		No	Unexpected weight change

HENT

Yes		No	Congestion
Yes		No	Dental problem
Yes		No	Drooling
Yes		No	Ear discharge
Yes		No	Ear pain
Yes		No	Facial swelling
Yes		No	Hearing loss
Yes		No	Mouth sores
Yes		No	Nosebleeds
Yes		No	Postnasal
Yes		No	Rhinorrhea (Runny Nose)
Yes		No	Sinus pain
Yes		No	Sinus pressure
Yes		No	Sneezing
Yes		No	Sore throat
Yes		No	Tinnitus (Ringing Ears)
Yes		No	Trouble swallowing
Yes		No	Voice change

Eyes

Yes		No	Eye discharge
Yes		No	Eye itching
Yes		No	Eye pain
Yes		No	Eye redness
Yes		No	Photophobia (Light Sensitivity)
Yes		No	Visual disturbance

Respiratory

Yes		No	Apnea (periods you stop breathing)
Yes		No	Chest tightness
Yes		No	Choking
Yes		No	Cough
Yes		No	Shortness of breath
Yes		No	Stridor (Noisy breathing)
Yes		No	Wheezing

Cardiovascular

Yes		No	Chest pain
Yes		No	Leg swelling
Yes		No	Palpitations (Feeling heart pound or race)

GI

Yes	No	Abd distention
Yes	No	Abdominal pain
Yes	No	Anal bleeding
Yes	No	Blood in stool
Yes	No	Constipation
Yes	No	Diarrhea
Yes	No	Nausea
Yes	No	Rectal pain
Yes	No	Vomiting

Endocrine

Yes	No	Cold intolerance
Yes	No	Heat intolerance
Yes	No	Polydipsia (Excessive thirst)
Yes	No	Polyphagia (Excessive hunger)
Yes	No	Polyuria

GU

Yes	No	Difficulty urinating
Yes	No	Dyspareunia (painful intercourse)
Yes	No	Dysuria (Painful urination)
Yes	No	Enuresis (Night time urination)
Yes	No	Flank pain
Yes	No	Frequency
Yes	No	Genital Sores

WOMEN

Yes	No	Hematuria (Blood in urine)
Yes	No	Menstrual Problem
Yes	No	Pelvic Pain
Yes	No	Urgency
Yes	No	Urine decreased
Yes	No	Vaginal Bleeding
Yes	No	Vaginal Discharge
Yes	No	Vaginal Pain

MEN

Yes	No	Penile discharge
Yes	No	Penile pain
Yes	No	Penile swelling
Yes	No	Scrotal swelling
Yes	No	Testicular pain
Yes	No	Urgency
Yes	No	Urine decreased

Muscular

Yes	No	Arthralgias (Joint pain)
Yes	No	Back pain
Yes	No	Gait problem
Yes	No	Joint swelling
Yes	No	Myalgias (Muscle pain)
Yes	No	Neck pain
Yes	No	Neck stiffness

Skin

Yes	No	Color change
Yes	No	Pallor (Pale color)
Yes	No	Rash
Yes	No	Wound

Allergies/Immuno

Yes	No	Env allergies
Yes	No	Food allergies
Yes	No	Immunocompromised

Neurological

Yes	No	Dizziness
Yes	No	Facial asymmetry
Yes	No	Headaches
Yes	No	Light-headedness
Yes	No	Numbness
Yes	No	Seizures
Yes	No	Speech difficulty
Yes	No	Syncope (Fainting)
Yes	No	Tremors
Yes	No	Weakness

Hematologic

Yes	No	Adenopathy (Swollen lymph nodes)
Yes	No	Bruises/bleeds easily

Psychiatric

Yes	No	Agitation
Yes	No	Behavior problem
Yes	No	Confusion
Yes	No	Decreased concentration
Yes	No	Dysphoric mood (Profound dissatisfaction)
Yes	No	Hallucinations
Yes	No	Hyperactive
Yes	No	Nervous/anxious
Yes	No	Self-injury (Thoughts/History)
Yes	No	Sleep disturbance
Yes	No	Suicidal ideas

WOMEN ONLY

At what age did your menstrual periods begin? _____	At what did your menstrual periods stop? _____
Period every_____days	Date of last menstruation: _____
Number of pregnancies _____	Number of live births _____
Are you pregnant? □ Yes □ No	Are you breastfeeding? □ Yes □ No
Date of last pap and rectal exam? _____	Date of last mammograms? _____

MEN ONLY

Do you examine your testicles for lumps?	□ Yes □ No
Do you usually get up to urinate during the night?	□ Yes □ No If yes, how many times per night? _____
Has your doctor told you that you have prostate disease?	□ Yes □ No
Have you had a PSA blood test?	□ Yes □ No If yes was it? □ Normal □ High

Date of last prostate and rectal exam? _____

HEALTH HABITS

Caffeine □ None □ Coffee □ Tea □ Cola If yes, how many of cups, cans, or bottles per day? _____

Alcohol Do you drink alcohol? □ Yes □ No How many drinks per week? _____

If yes, what kind? □ Beer □ Wine □Liquor □ Other _____

Tobacco □ Never Smoked □ Not Currently Year quit?_____Exposed to second hand smoke_____Smoking cessation info. Provided □

□ Cigarettes: packs per day_____ Number of years_____ □ Pipe: times per day_____ Number of years _____

□ Chew: amount per day_____ Number of years_____ □ Cigars: number per day_____ Number of years _____

Marijuana Do you currently have a prescription for medical marijuana? □ Yes □ No

Drugs Do you currently or have you ever used recreational drugs or street drugs? □ Yes □ No

SOCIAL HISTORY

WORK STATUS: □ Currently Working □ Retired □ Disabled How _____

OCCUPATION: Current_____Previous_____

LIVING WITH: □ Spouse □ Children #_____□ Other_____□Alone □Pets_____

LIVING IN: □ House □ Apartment □ Retirement Home □ Assisted Living □ Other _____

FAMILY HEALTH HISTORY

Relationship to You	Cancer History (please specify)	Age at Cancer Diagnosis	Other Medical History	Still living?	If Deceased?
Mother	☐ Yes: Type:_____ ☐ No			☐ Yes ☐No Age:	Age at death:
Father	☐ Yes: Type:_____ ☐ No			☐ Yes ☐No Age:	Age at death:
Maternal grandmother (Mom's mom)	☐ Yes: Type:_____ ☐ No			☐ Yes ☐No Age:	Age at death:

Maternal grandfather (Mom's dad)	☐ Yes Type:_____ ☐ No			☐Yes ☐No Age:	Age at Death:
Paternal grandmother (Dad's mom)	☐ Yes Type:_____ ☐ No			☐Yes ☐No Age:	Age at Death:
Paternal grandfather (Dad's dad)	☐ Yes Type:_____ ☐ No			☐Yes ☐No Age:	Age at Death:

- How many children do **you** have? # Sons: _____ # Daughters: _____
- How many siblings do **you** have? # Brothers: _____ # Sisters: _____
- How many siblings does **your mother** have? # Brothers: _____ # Sisters: _____
- How many siblings does **your father** have? # Brothers: _____ # Sisters: _____

Please list any OTHER blood relatives who have had cancer or colon polyps:

Relationship to You (i.e. cousin, children)	**Side of Family**	**Type of Cancer and/or write "colon polyps"**	**Age at diagnosis**	**Still living?**	**Current age or age at death**
	☐ Mom's ☐Dad's			☐Yes ☐No	
	☐ Mom's ☐Dad's			☐Yes ☐No	
	☐ Mom's ☐Dad's			☐Yes ☐No	
	☐ Mom's ☐Dad's			☐Yes ☐No	
	☐ Mom's ☐Dad's			☐Yes ☐No	

Where did your Mother's family originate from? *(i.e. Germany, Africa, England, etc.)*

_____

Where did your Father's family originate from? *(i.e. Germany, Africa, England, etc.)*

_____

Are you of Ashkenazi Jewish descent (Eastern European Jewish)? ☐ No ☐ Yes

Are there any other diseases that run in your family? ☐ No ☐ Yes, If yes, what and in whom?

_____

_____

SPECIAL NEEDS/COMMENTS/CULTURAL ASSESSMENT

Is there something in your cultural or religious practices that we need to know to care for you?

☐ Yes (explain) ☐ NO

_____

_____

ARE YOU INTERESTED IN A CLINICAL TRIAL?

☐ YES ☐ NO

Reviewed By:_____ Date:_____

Physician's Signature

Sparrow Health System General Consent For Treatment

Sparrow

Patient Name: MRN:
Date:

I CONSENT TO THE FOLLOWING:

- Medical care for inpatient, outpatient, or emergency services at Sparrow Health System
- Treatment as ordered or deemed appropriate by any physicians, consultants, advance practice providers or other health care providers.
- Treatment at all Sparrow locations, including virtual health services provided by video, telephone or email.
- The disposal of any specimens or tissues taken from my body during my hospitalization or treatment.
- The presence of, and treatment by, medical residents who are physicians in training at Sparrow Health System.
- The care of my newborn baby, if I am here to give birth.
- My picture may be taken and used as part of my medical record for identification purposes.
- Any form of visual media may be taken of me during the course of my treatment and used for teaching purposes.
- I may receive autodialed or pre-recorded telephone calls from Sparrow Health System, its lawyers or agents. I also consent to receive text messages and/or emails from Sparrow Health System, its lawyers or agents. My consent is not a condition of my treatment.

I UNDERSTAND:

- 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 results of care, treatment or examination.
- Testing of my blood for HIV and hepatitis may be required if a health care professional or first responder (including police, firefighter, paramedic, etc.) sustains an exposure to my blood or other bodily fluids. I understand that this testing is permitted under Michigan law, and should such testing occur, I will not be billed for it.
- That there are patient rights and responsibilities that I will review and ask questions if I do not understand.

Initial Here

BILLING:

- I understand that Sparrow Health System will submit claims to my insurance carrier(s) on my behalf. This may include the release of medical information to any person or organization that is legally or contractually responsible for payment of my bills for the services I received. Information may be sent to payors electronically, and may include my diagnosis, treatments, drug/alcohol use, HIV or other infectious diseases, or mental health treatment.
- I hereby assign to Sparrow and Health Care Providers all of my insurance and managed care benefit due to me for services rendered to me by Sparrow Hospital and/or Health Care Providers. I authorize my insurance company and /or my managed care company to make payment directly to Sparrow and/or Health Care Providers.
- I understand that some physicians services I receive are hired separately and that I may be billed by both Sparrow and any attending or consulting providers separately. I consent to Sparrow disclosure of my health information only to attending and consulting providers for billing purposes.
- I understand that I am responsible for the charges for my medical treatment.

Sparrow Health System General Consent For Treatment

Patient Name: MRN:
Date:

- I agree to pay my account in full after I receive services and to pay any legal fees and interest at the legal rate which results due to my not paying the balance. I understand that neither Sparrow nor Health Care Providers accepts liability for failure to meet any precertification required by my insurance carrier, and I agree to pay for all services if precertification is denied by my insurance carrier.

VALUABLES:

- I understand that Sparrow Health System is not responsible for my valuables, personal belongings or any property kept in my possession while I am a patient at Sparrow.
- I understand that Sparrow recommends that all personal belongings be taken home or given to a family member/friend and I accept responsibility for any personal belongings left in my possession.
- I understand that I should not leave my valuables unattended, on my food trays, or in my bed. I also understand that all patient owned medical equipment should be clearly labeled with my name.

Initial Here

SIGNATURES:

I have read this form and I understand it. My questions have been answered.

_____

Signature of Patient/Patient's Representative Time: Date:

Witness Signature:

_____ Time: Date:

Second witness if verbal consent:

_____ Time: Date: