



**CEDARS-SINAI MEDICAL CENTER**  
**Medical Genetics**

Dear Patient,

Thank you for expressing interest in our Clinic. Enclosed, you will find the following paperwork necessary for your appointment:

- A Genetics questionnaire
- Registration Form
- Authorization for Use or Disclosure of Health Information (see below)

It may seem like a lot of paperwork, but it is necessary and helpful to our staff in preparing for your visit. Please make sure to take the time to fill out the questionnaire completely and remember to return the packet to us as soon as you can. Unfortunately, we do need to receive the packet before we are able to schedule an appointment. The completed questionnaire and any medical records that are sent will be reviewed by one of our genetic counselors to ensure that our Genetics team has the appropriate information so that we can offer you a complete and informative visit. After the packet is reviewed, someone from our office will call you to schedule an appointment. Please note, it is the nature of our practice to provide each client with individualized care and it is not unusual for appointment to last from 1 ½ to 2 hours.

The Authorization for Use or Disclosure of Health Information form has been provided to assist you in obtaining any of your medical records. Please make copies and send the form to the private physicians and/or hospitals that have been involved in your care. Medical records contain very private information and legally, only you can authorize for them to be sent to other doctors or hospitals for review. It is your responsibility to obtain the necessary medical records.

If your insurance is an **HMO**, you must obtain authorization from the primary doctor **before** the appointment can be scheduled. If your insurance is a **PPO**, it is suggested that you contact your insurance provider to determine if an authorization is needed for a Genetics evaluation to avoid being billed. Co-payments are collected at the time of check-in to the clinic. **Please bring your insurance card and authorization letter (if applicable) with you to the appointment.** Please notify us immediately if insurance authorization is denied. You can contact us if you need additional assistance.

Sincerely,

Tami Kendra, Clinic Coordinator  
Cedars-Sinai Medical Center  
Medical Genetics Institute  
Phone: 310-423-9914  
Fax: 310-423-2080

## MEDICAL GENETICS - ADULTS

Date:	Expected DOS:
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**PATIENT INFORMATION:**

Name:	DOB:	Sex:	MRN:
Address:		City, State, Zip Code:	
Mother's Maiden Name:		Race:	Birthplace:
Home #:	Social Security No:		Religion:
Marital Status:			

**EMERGENCY CONTACT:**

Name:	Address:	Phone Number
Employer:	Occupation:	DOB:
Employ Phone:	Employ. Address:	
Name:	Address	Phone Number
Employer:	Occupation:	DOB:
Employ Phone:	Employ. Address:	

**PRIMARY CARE PHYSICIAN INFORMATION:**

Physician:	Contact:
Address:	City, State:
Phone:	Fax:

**REFERRING PHYSICIAN INFORMATION [If Different from Primary Care Physician]:**

Physician:	Contact:
Address:	City, State, Zip:
Phone:	Fax:

**INSURANCE INFORMATION: (circle one) PPO HMO POS EPO**

Insurance Name:		Phone #	
		Medical Group Phone#	
Address:		City, State, Zip:	
Subscriber:	ID #:	Group #:	
Plan#:	Effective:		Co-Pay: \$
Diagnosis:		Medications:	
COMMENTS/NOTES			



Cedars-Sinai Medical Center  
 Medical Genetics Birth Defects Center

**NEW PATIENT QUESTIONNAIRE  
 ADULT**

PATIENT I.D.

Patient's Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
<b>Referred by:</b>		
Address:	Phone Number: (   )	
	Fax Number: (   )	
<b>Primary Care Physician (if different from referring physician):</b>		
Address:	Phone Number: (   )	
	Fax Number: (   )	
<b>Why have you been referred to Genetics clinic?</b>		
<b>How and when did this problem present?</b>		



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**NEW PATIENT QUESTIONNAIRE  
 ADULT**

PATIENT I.D.

**What studies have been performed on you?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> X-rays              | <input type="checkbox"/> Chromosome Analysis          | <input type="checkbox"/> Eye/Vision Exam    |
| <input type="checkbox"/> CT Scan             | <input type="checkbox"/> Specialized Genetics Studies | <input type="checkbox"/> Hearing Evaluation |
| <input type="checkbox"/> MRI                 | <input type="checkbox"/> Other Bloodwork              | <input type="checkbox"/> EEG                |
| <input type="checkbox"/> Ultrasound          | <input type="checkbox"/> Developmental Assessment     | <input type="checkbox"/> Skin Biopsy        |
| <input type="checkbox"/> Organ Biopsy        | <input type="checkbox"/> EKG (electrocardiogram)      | <input type="checkbox"/> Echocardiogram     |
| <input type="checkbox"/> Other Studies _____ |   |   |

*Please ensure that we have the results of any of the above studies that you have checked.*

**Your Birth History: (if known)**

Length of Pregnancy: \_\_\_\_\_ Delivery Type:  Vaginal  C-section

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Head Circumference: \_\_\_\_\_

Presentation:  Head first  Bottom first  Other \_\_\_\_\_

Hospital: \_\_\_\_\_ Apgar Scores, if known: \_\_\_\_\_

Birth Complications, if any: \_\_\_\_\_

Length of stay in nursery: \_\_\_\_\_

Reason for prolonged stay, if applicable: \_\_\_\_\_

**Your Medical History (please check all that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hospitalizations                | <input type="checkbox"/> Surgeries           | <input type="checkbox"/> Chronic Medical Issues |
| <input type="checkbox"/> Significant Illnesses           | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Motor Delays           |
| <input type="checkbox"/> Speech Delays                   | <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Hearing Problems       |
| <input type="checkbox"/> Feeding Difficulties            | <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Growth Problems        |
| <input type="checkbox"/> Unusual Habits                  | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Behavior Problems      |
| <input type="checkbox"/> Attention Deficit/Hyperactivity |  |   |



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**NEW PATIENT QUESTIONNAIRE  
ADULT**

PATIENT I.D.

**If you checked any of the above, please explain:**

**List current medications, if any, with doses:**

**List physicians involved in your care:**

<u>Name</u>	<u>Specialty</u>	<u>Last Visit</u>	<u>Next Appt.</u>
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**Family History**

Please list any other relatives that have been diagnosed with any disorders.



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**NEW PATIENT QUESTIONNAIRE  
ADULT**

PATIENT I.D.

**Your Mother's History:**      DOB: \_\_\_\_\_      Height: \_\_\_\_\_  
# of Pregnancies \_\_\_\_\_      # of Livebirths \_\_\_\_\_  
# of Miscarriages \_\_\_\_\_      # of Stillbirths \_\_\_\_\_

Medical Problems/Medications:

**Your Father's History:**      DOB: \_\_\_\_\_      Height: \_\_\_\_\_  
Medical Problems/Medications:

Are your mother and father related? (Cousins, for example)

Yes       No       Possibly

**List your brothers and sisters (if half-siblings, please note maternal or paternal):**

Name      Age      Sex      Health      Full or half-sibling



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PATIENT I.D.

**Your Grandparents:**

	Name	Age	Ethnic background	Health
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

**List your mother's brothers and sisters (if half-siblings, please note maternal or paternal):**

Name	Age	Sex	Health	Full or half-sibling
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**List your father's brothers and sisters (if half-siblings, please note maternal or paternal):**

Name	Age	Sex	Health	Full or half-sibling
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**NEW PATIENT QUESTIONNAIRE**  
**ADULT**

PATIENT I.D.

Is there any history in your family of the following? (please check all that apply)

- Miscarriages
- Birth defects
- Developmental delay
- Psychiatric disorders
- Learning disorders
- Other disease (please list):
- Stillbirths
- Unusual features
- Cancer
- Attention deficit/hyperactivity
- Autism
- Newborn/childhood deaths
- Mental retardation
- Infertility

**Review of Systems:**

Please check all that apply:

- General:  Fever  Chills  Sweats  Change in weight  
 Fatigue  Temperature sensitivity

- Skin:  Rashes  Easy bruising  Eczema  Birthmarks  
 Lumps  Skin changes  Nail changes

- Head:  Headaches

- Eyes:  Redness  Discharge  Change in vision  
 Glaucoma  Cataracts  Eyeglasses  
 Sensitivity to light

- Ears:  Infections  Ringing  Hearing impairment

- Nose:  Bleeding  High frequency of 'colds'

- Mouth/  
Throat:  Teeth problems  Gum problems  Frequent sore throats  
 Unusual voice

- Neck:  Lumps  Pain  Thyroid trouble

- Chest:  Cough  Pain  Respiratory problems  
 Asthma  Wheezing  Pneumonia  
 Snoring  Shortness of breath while sleeping



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PATIENT I.D.

- Heart:       Palpitations       Shortness of breath with exertion  
                  Heart murmur       Blood pressure problems
- Digestive:     Poor appetite       Excessive hunger       Thirst  
                  Nausea       Swallowing difficulty       Constipation  
                  Diarrhea       Vomiting       Stomach aches  
                  Liver disease       Food intolerance
- Urinary:       Pain on urination       Frequent urination  
                  Blood in urine       Bed-wetting  
                  Strong odor of urine       Unusual color of urine
- Muscle/:       Weakness       Cramps       Stiffness  
Bone       Limitation of movement       Joint pain
- Neurologic:  Fainting       Dizziness       Numbness  
                  Tingling       Tremors       Psychiatric disorder  
                  Mood changes       Unsteady gait       Behavioral change  
                  Seizures       Tics       Speech disorders  
                  Sleep disorders

Is there anything else about your health that you would like us to know?

Thank you for taking the time to complete this form.



CEDARS-SINAI MEDICAL CENTER

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Persons/Organizations authorized to use or disclose the information: 1 \_\_\_\_\_

Persons/Organizations authorized to receive the information (must include name, address, phone number, fax number): \_\_\_\_\_

This Authorization applies to the following information (select only one of the following): 2

A.  All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: \_\_\_\_\_

Only the following records or types of health information (including any dates): \_\_\_\_\_

B. I specifically authorize release of the following information (check as appropriate): 2,3

Mental Health treatment information

HIV test results

Alcohol / Drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: 4  Patient request; OR  Other: \_\_\_\_\_

EXPIRATION

This Authorization expires (not to exceed 24 months): 5 \_\_\_\_\_

(Insert Date or Event)

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: \_\_\_\_\_
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization. 6
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. 7
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless

unless such disclosure is specifically required or permitted by law.

- I may inspect or obtain a copy of the health information that I am being asked to use or disclose. If this box  is checked, the Requestor will receive compensation for the use or disclosure of my information.

### SIGNATURE

Date: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

Signature: \_\_\_\_\_

*(Patient / Representative / Spouse / Financially Responsible Party)*

If signed by someone other than the patient, state your legal relationship to the patient: <sup>8</sup> \_\_\_\_\_

Witness: \_\_\_\_\_

Hospital Representative Processing Request: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature)

- <sup>1</sup> If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
  - <sup>2</sup> This form may **not** be used to release both psychotherapy notes and other types of health information (see 45 CFR“164.508 (b)(3)(ii). If this form is being used to authorize the release of psychiatric health information, a separate form must be used to authorize release of any other health information. An authorization for use or disclosure of HIV test results must **specifically** state that it authorizes the use or disclosure of HIV test results and must be signed by a witness.
  - <sup>3</sup> If mental health information covered by Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party.
  - <sup>4</sup> The statement “at the request of the individual” is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
  - <sup>5</sup> If authorization is for the use or disclosure of protected health information for research, including the creation and maintenance of a research database or repository, the statement “end of research study”, “None”, or similar language is sufficient.
  - <sup>6</sup> Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR“164.508 (d)(1), (e) (2)).
  - <sup>7</sup> If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
- <sup>8</sup> The requestor is to complete this section of the form.

**Reference:** Welfare and Institutions Code Section 5328.7