

Medical Intake Form--Form I: Instructions: a. Print. Complete. Scan or snail mail. OR

b. Save these forms to your desktop. Complete by typing on the fillable forms. Print. Sign. Fax to 415-346-8652 or email as attachment to mail@thesecondopinion.org

Name: _____ Date of Birth: _____ Gender: _____

Email: _____ Phone: _____
Home Mobile

Address: _____

County: _____

Contact person, if other than patient: _____

Contact person's phone and or email : _____

Type of Cancer: _____

When were you diagnosed with cancer? _____

Have you received a prior Second Opinion? _____ If so where and when? _____

Are you planning to Obtain Additional Opinions? _____ If so where and when? _____

☐

I will need the help of translator services.

Which Language? _____

How did you hear about us?

Why are you seeking a 2nd opinion?

Please tell us briefly about your cancer diagnosis and treatment to date. This will help us determine the records that will be needed for your panel review:

FORM II: PHYSICIANS and MED INFO

Date: _____

Name: _____

Phone: _____
Home Mobile

Email: _____

Type of Cancer: _____

Have you received a prior Second Opinion? _____ If so where and when? _____

Are you planning to Obtain Additional Opinions? _____ If so where and when? _____

☐

I will need the help of translator services.

Which Language? _____

**To the best of your knowledge, please list all physicians and medical facilities involved in your care.
Addresses and phone numbers are appreciated.****Oncologist:**

, MD

Facility/Hospital: _____
Address: _____
Phone/Fax: _____
Dates under care: _____**Surgeon:**

, MD

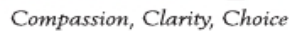
Facility/Hospital: _____
Address: _____
Phone/Fax: _____
Dates under care: _____**Radiation Oncologist:**

, MD

Facility/Hospital: _____
Address: _____
Phone/Fax: _____
Dates under care: _____**Other Specialist:**

, MD

Facility/Hospital: _____
Address: _____
Phone/Fax: _____
Dates under care: _____**OTHER INFO: Hospital/Facility:**_____



Yes Partial with Co-Pay No I don't know

PATIENT HEALTH INFORMATION RELEASE FORM

I HEREBY AUTHORIZE:

NAME OF HOSPITAL, DOCTOR, LABORATORY OR DEPARTMENT

ADDRESS

CITY

STATE

ZIP CODE

TO RELEASE TO: Howard B. Kleckner, MD
c/o Lori Bode
thesecondopinion
3208 King Street
Berkeley, CA 94703
FX:415-346-8652
PH:510-609-2393

RECORDS AND INFORMATION OF:

PATIENT NAME

MEDICAL NUMBER

DATE OF BIRTH

ADDRESS

TELEPHONE NUMBER

INTENDED USE: SECOND OPINION CANCER CONSULTATIVE PANEL

Duration: I understand that this authorization is effective immediately and shall be valid for one year.

Right to Revoke: I understand that I may revoke this authorization in writing at any time.

Reuse: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.

RECORDS TO BE RELEASED:

ALL EHR/PHI MEDICAL RECORDS RELATED TO CANCER DIAGNOSIS:

MD NOTES, PLANS , OPERATIVE REPORTS, SUMMARIES, LABS
IMAGING STUDIES ON DISC, X-RAYS AND REPORTS, CTs, MRIs,PET scans
NUCLEAR SCANS AND REPORTS and Mammograms if applicable
PATHOLOGY SLIDES AND REPORTS
GENETIC TEST RESULTS

Patient signature: _____

Date: _____