thesecondopinion

Compassion, Clarity, Choice

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: _____
_____
_____
_____
_____
_____
_____

thesecondopinion

Compassion, Clarity, Choice

FORM III: STATISTICAL QUESTIONNAIRE

Name: (initials) _____ **Age:** _____ **Date:** _____ **Gender:** _____

Type of Cancer: _____

How did you hear about our service? _____

The information below is used only to provide statistics to potential funding organizations. No names will be used.

Ethnic identity: With which ethnic group/s do you identify? (e.g. African American, Asian, etc.)

Are you: *(Please check the appropriate box.)*

☐ Employed ☐ Retired ☐ Unemployed ☐ Disability ☐ Other

Are you: ***(****Please check one box below.)*

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Your Annual Income: (*Please check one box below)*

☐ $50,000 or Less ☐ $51,000 -$79,000

☐ $80,000-100,000 ☐ $101,000 or Above

Is your medical care covered by *(Please check all boxes that apply)*:

☐ Medical insurance: (e.g. Aetna, Kaiser, Healthy SF, Health Net,
☐ etc.) Medical Insurance and Medicare
☐ Medicare Only
☐ Covered California/Affordable Care Act: Kaiser, Blue Shield, etc.
☐ Medi-Cal
☐ Uninsured
Other

While we do not bill your insurance for our free services, we would like to know if your insurance or health plan covers the cost of a 2nd Opinion outside of your plan's network?
(Please check the appropriate box below.)

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

FORM **IV signature required**

thesecondopinion

Compassion, Clarity, Choice

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: _____