SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

Welcome to Shenandoah Oncology and thank you for choosing us as your Oncology and Hematology provider. Our primary goal is to provide quality medical care which is easily accessible and responsive in your time of need. Whether you are seeing us for Oncology (cancer) or benign Hematology (non-cancer blood) concerns, our staff includes a comprehensive interdisciplinary team of medical and administrative professionals who will strive to exceed your expectations. We aim to ensure your experience with us is as comfortable and as stress free as possible.

At Shenandoah Oncology, we take a team approach to healthcare delivery. Each team consists of a board-certified hematologist oncologist, an office-based nurse practitioner, a dedicated inpatient nurse practitioner, a clinical medical assistant, and a dedicated scheduler. Additionally, we have a licensed social worker on staff who can help guide you through your emotional, social, and family concerns. If needed, you will also be assigned a nurse in our treatment room who specializes in the treatment and care of oncology and hematology patients.

Depending on your diagnosis, you will see either the doctor or office-based nurse practitioner at your first visit. Together, they will develop a plan of care for you that will best meet your individual needs. Your team will also assist in coordinating care with other providers, specialists and community resources as needed.

Enclosed you will find an appointment card with your provider's name, visit date and time. Again, thank you for choosing Shenandoah Oncology.

SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW PATIENT HISTORY FORM

Patient Name: _____ _____
Last First M.I. Today's Date

_____ _____ _____ _____ _____
Referred By DOB Marital Status Height Weight

HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.

_____

_____

_____

_____

PAST HISTORY: If you need additional space, it is provided on the last page.

Surgeries (with dates)	Medical Conditions

Blood Transfusion History:

☐ Yes ☐ No If yes, when? _____

Reproductive History:

Number of pregnancies _____ Number of children: _____ Age at first pregnancy: _____

Age at first period _____ Age at last period: _____ Are you pregnant now ☐Y ☐N

Hysterectomy: ☐Y ☐N Ovaries removed ☐Y ☐N

Hormone use: ☐Y ☐N Oral contraceptive use ☐Y ☐N

Preventive Health Maintenance: Please provide dates for each answer or write "none"

Circle One: Male OR Female

Last mammogram: _____ Last Prostate exam: _____

Last Pap smear: _____ Last PSA screening: _____

Last colonoscopy: _____ Last Flu vaccine: _____

Last bone density scan: _____ _____

Last pneumonia vaccine: _____ _____

SOCIAL HISTORY

Substance	Do you use?	What Type?	How Much?	How Often?	If quit, when?
Alcohol:	☐Y ☐N				
Tobacco:	☐Y ☐N				
Caffeine:	☐Y ☐N				
Recreational Drugs:	☐Y ☐N				

FAMILY HISTORY: **Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)**

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:			☐Y ☐N	Brothers:			☐Y ☐N
Father:			☐Y ☐N				☐Y ☐N
Grandmother (P):			☐Y ☐N				☐Y ☐N
Grandfather (P):			☐Y ☐N	Sisters:			☐Y ☐N
Grandmother (M):			☐Y ☐N				☐Y ☐N
Grandfather (M):			☐Y ☐N				☐Y ☐N
				Children:			☐Y ☐N
							☐Y ☐N
							☐Y ☐N

REVIEW OF SYSTEMS

Constitutional		
Weight Loss	☐Y	☐N
Poor Energy Level	☐Y	☐N
Fever	☐Y	☐N
Chills	☐Y	☐N
Night Sweats	☐Y	☐N

Eyes		
Double Vision	☐Y	☐N
Vision Loss	☐Y	☐N
Flashing Lights	☐Y	☐N

ENT/Mouth		
Ringing in Ears	☐Y	☐N
Hearing Loss	☐Y	☐N
Oral Ulcers	☐Y	☐N
Mouth Pain	☐Y	☐N
Sore Throat	☐Y	☐N
Difficulty Swallowing	☐Y	☐N
Hoarseness	☐Y	☐N

Cardiovascular		
Chest Pain	☐Y	☐N
Palpitations	☐Y	☐N
Fainting Spells	☐Y	☐N
Leg Swelling/Pain	☐Y	☐N
Arm Swelling/Pain	☐Y	☐N

Respiratory		
Cough	☐Y	☐N
Wheezing	☐Y	☐N
Shortness of Breath	☐Y	☐N
Coughing Blood	☐Y	☐N
Pain with Breathing	☐Y	☐N

Breast		
Mass	☐Y	☐N
Pain	☐Y	☐N
Nipple Discharge	☐Y	☐N
Change in Size	☐Y	☐N
Change in Shape	☐Y	☐N

Gastrointestinal		
Nausea	☐Y	☐N
Vomiting	☐Y	☐N
Jaundice	☐Y	☐N
Abdominal Pain	☐Y	☐N
Maroon/Black Stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Vomiting Blood	☐Y	☐N
Difficulty Swallowing	☐Y	☐N

Urinary		
Painful Urination	☐Y	☐N
Blood in Urine	☐Y	☐N
Increased Frequency	☐Y	☐N
Loss of Control	☐Y	☐N
Impotence	☐Y	☐N

Gynecological		
Vaginal Discharge	☐Y	☐N
Pelvic Pain	☐Y	☐N
Abnormal Bleeding	☐Y	☐N

Musculoskeletal		
Muscle Pain	☐Y	☐N
Spine Tenderness	☐Y	☐N
Swollen Joints	☐Y	☐N
Joint Redness	☐Y	☐N
Bone Pain	☐Y	☐N

Skin		
Rash	☐Y	☐N
Nodules	☐Y	☐N
Itchiness	☐Y	☐N
Lesions	☐Y	☐N

Neurological		
Confusion	☐Y	☐N
Seizures	☐Y	☐N
Fainting Spells	☐Y	☐N
Tremors	☐Y	☐N
Speech Change	☐Y	☐N
Headache	☐Y	☐N
Abnormal Gait	☐Y	☐N
Weakness	☐Y	☐N
Sensory Change	☐Y	☐N

Psychiatric		
Anxiety	☐Y	☐N
Depression	☐Y	☐N

Endocrine		
Excessive Urine	☐Y	☐N
Excessive Thirst	☐Y	☐N
Hot Flashes	☐Y	☐N
Heat/Cold Intolerance	☐Y	☐N

Hematological		
Nose Bleeds	☐Y	☐N
Bleeding Gums	☐Y	☐N
Easy Bruising	☐Y	☐N

Lymphatic		
Enlarged Lymph Nodes	☐Y	☐N
Swelling in Arms/Legs	☐Y	☐N

Radiation/Chemo History:

Previous Radiation Therapy: ☐ Yes ☐ No If yes, where?_____

Previous Chemotherapy: ☐ Yes ☐ No If yes, where?_____

Patient Preferences:

Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of? ☐ Yes ☐ No

Do you have a durable power of attorney or a living will? ☐ Yes ☐ No

Do you have a current Advanced Directive? ☐ Yes ☐ No

If Yes, please bring a copy in for our records.
If No, please let us know if you would like to make an appointment with a Nurse Practitioner to complete your advance directives.

Are there any language barriers that the staff needs to be aware of? ☐ Yes ☐ No

Do you feel unsafe or threatened by anyone? ☐ Yes ☐ No

Do you have any thoughts of hurting yourself or anyone else? ☐ Yes ☐ No

REFERRING PHYSICIANS: Please list all referring physicians and others you are currently seeing.

Physician	Address	Phone Number

PHARMACY: Please list your pharmacy information.

Pharmacy	Address	Phone Number

Are you a veteran? Yes or No If yes, which branch of military did you serve and in what years did you serve? _____

Have you ever accessed the VA for any services? Yes or No If so, what services did you use?

_____

Are you eligible for Veteran's Benefits due to a spouse's military service? Yes or No

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above.

_____

_____

_____

_____

_____

Patient Signature: _____

Patient Printed Name: _____

Date: _____

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Current Medication Form

Name: _____
DOB: _____

Pharmacy Name: _____
Address: _____
Phone/Fax: _____

Allergies & Adverse Reactions

Medication	Reaction

Current Medications

Prescription, over-the-counter, and herbal remedies

Medication	Dose	Schedule

Reviewed By: _____ **Date:** _____

SHENANDOAH ONCOLOGY

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Acknowledgment of Receipt of Notice of Privacy Practices

Shenandoah Oncology, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Shenandoah Oncology, P.C.

Printed Name: _____ DOB: _____

Signature: _____

Name of Representative (if appropriate):

_____

Signature of Representative (if appropriate):

_____

Shenandoah Oncology, P.C. Use Only

Date acknowledgement received: _____

OR

Reason acknowledgement was not obtained and employee signature:

_____

_____

Signature:_____

SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

AUTHORIZATION FOR RELEASE OF RECORDS TO SHENANDOAH ONCOLOGY, P.C.

Medical Records Phone: 540-450-0682
Medical Records Fax: 540-667-3408

Date: _____

I hereby authorize Dr. _____to release information from the records of:

_____ _____
Patient Name Date of Birth

_____ _____
Street Address City, State, Zip Code

_____
Phone Number

I authorize that the following records may be sent:

- ☐ Physician notes/letters
- ☐ Hospital Records
- ☐ Treatment Records
- ☐ Laboratory and Pathology results
- ☐ Pathology slides & tissue blocks
- ☐ Radiology reports and disks
- ☐ All of the above

This authorization will expire in twelve months following the date of signature, unless otherwise specified below.

Expiration Date:_____

Patient Signature:_____ Date:_____

SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

Authorization of Release of Medical Information

Date: _____

I hereby authorize Shenandoah Oncology, P.C. to release information from the records of:

_____ _____

Patient Name Street Address

_____ _____

City, State, Zip Code Telephone Number

_____

Date of Birth

_____

Signature of Patient

You may release this information to the following individuals:

_____ _____

Name & Relationship Phone Number

_____ _____

Name & Relationship Phone Number

_____ _____

Name & Relationship Phone Number

SHENANDOAH ONCOLOGY

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User Electronic Mail Authorization Form
Patient Portal: My Care Plus

The Patient Portal, My Care Plus, offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire within 7 days. If you should change email addresses, please contact your physician's office in order to provide your new email information so that you will continue to receive updates and other pertinent information about your record. Please choose an email address **(one email address per patient)** that will not be subject to access by anyone you do not trust. Please ensure the email address you provide is not a duplicate email address in use by another patient here at Shenandoah Oncology.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

You are receiving access to the Portal; the terms and conditions of the Portal shall apply to this User Electronic mail Authorization Form. **Please write legibly.**

_____ Patient's Name (Printed)

_____ Patient's Date of Birth

_____ Email Address (Print legibly)

Authorized user is:

☐ Patient

☐ Patient's Designee

_____ Patient's Designee's Name (Printed)

_____ Patient's Designee's Signature

_____ Patient's Signature

_____ Date

MRN		For Office Use Only – Staff Initials		Date	

ATTENTION: If you speak Spanish, Korean, Vietnamese, Chinese, Arabic, Tagalog, Persian, Amharic, Urdu, French, Russian, Hindu, German, or Bengali, language assistance services, free of charge, are available to you. Call Front Office Supervisor at 540-662-1108

Atención: Si usted habla español, Coreano, vietnamita, Chino, Árabe, neerlandés, persa, amárico, Urdu, Francés, Ruso, hindú, alemán o bengalí, servicios de asistencia de idioma, de forma gratuita, están disponibles para usted. Llame al Supervisor de recepción en 540-662-1108

주의: 만약 당신이 말하는 스페인어, 한국어, 베트남어, 중국어, 아랍어, 타갈로그어, 페르시아어, Amhric, Urda, 프랑스어, 러시아어, 힌두교, 독일어, Dengali, 또는 크루, 언어 지원 서비스, 무료로, 당신이 사용할 수 있습니다. 티파니 Front Office Supervisor tai 540-662-1108에서 호출

Chú ý: Nếu bạn nói tiếng Tây Ban Nha, Hàn Quốc, Việt Nam, Trung Quốc, tiếng ả Rập, tiếng Tagalog, tiếng Ba tư, tiếng Amhara, tiếng Urdu, Pháp, Nga, Hindu, Đức hoặc tiếng Bengali, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi cho văn phòng mặt trận giám sát viên tại 540-662-1108

注意:**如果您**讲西班牙语、韩语、越南语、中文、阿拉伯语、塔加禄语、波斯语、阿姆法语、乌尔都语、法语、俄语、印度语、德语或孟加拉语,**您可以免**费获得语言协助服务。 **致**电前台主管 540-662-1108

تنبيه: إذا كنت أتكلم الإسبانية الكورية، الفيتنامية، الصينية، العربية، التغالوغيه، الفارسي، الأمهرية، الأردية، الفرنسية، الروسية، الهندوسية، أو الألمانية أو البنغالية، خدمات المساعدة اللغوية، مجاناً، تتوفر لك. استدعاء المشرف على مكتب الجبهة في 540-662-1108

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Front Office Supervisor (540) 662-1108

ትኩረት: እናንተ ስፓንኛ መናገር ከሆነ, ኮሪያኛ, ቬትናምኛ, ቻይንኛ, አረብኛ, ታጋሎግ, የፋርስ, አማርኛ, Urda, ፈረንሳይኛ, ሩሲያኛ, የሂንዱ, ጀርመንኛ, ቤንጋሊ, ወይም Kru, የቋንቋ እርዳታ አገልግሎቶች, ከክፍያ ነፃ, ለእርስዎ የሚገኙ ናቸው. 540-662-1108 ላይ ቲፋኒ Front Office Supervisor ይደውሉ

توجه: اگر اسپانیایی کره ای، ویتنامی، چینی، عربی، تاگالوگی، فارس، امهری، اردو، فرانسوی، روسی، هندو، آلمانی یا بنگالی حرف زبان خدمات امداد، رایگان، به شما در دسترس هستند. سرپرست دفتر جلو در 540-662-1108 تماس بگیرید

ATTENTION : Si vous parlez espagnol, coréen, vietnamien, chinois, arabe, Tagalog, persan, amharique, ourdou, Français, russe, hindou, allemand, Bengali ou Kru, services d'assistance linguistique, gratuites, sont à votre disposition. Front Office Supervisor appel à 540-662-1108

ВНИМАНИЕ: Если вы говорите, испанский, корейский, вьетнамский, китайский, арабский, тагальский, Персидский, Турецкий, урду, французский, Русский, индуистской, немецкий, бенгальский или КРУ, языковых служб помощи, бесплатно, доступны для вас. Бриден Front Office Supervisor звонка в 540-662-1108

ध्यान: यदि आप स्पेनिश, कोरियाई, वियतनामी, चीनी, अरबी, तागालोग, फारसी, Amharic, उर्दू, फ्रेंच, रूसी, हिंदू, जर्मन, या बंगाली, भाषा सहायता सेवाओं, नि: शुल्क बोलते हैं, आप के लिए उपलब्ध हैं। 540-662-1108 पर फ्रंट कार्यालय पर्यवेक्षक कॉल करें

Achtung: Wenn Sie Spanisch, Koreanisch, Vietnamesisch, Chinesisch, Arabisch, Tagalog, Persisch, Amharisch, Urdu, Französisch, Russisch, Hindu, Deutsch oder Bengali sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie Front-Office Supervisor bei 540-662-1108

দৃষ্টি আকর্ষণ: স্প্যানিশ, কোরিয়ান, ভিয়েতনামি, চাইনিজ, আরবি, ট্যাগালোগ, পারস্য, আমহারিক, উর্দু, ফরাসি, রুশ, হিন্দু, জার্মান বা বাংলা কথা বলে। তবে ভাষা সহায়তা, ফ্রি, তোমার কাছে পাওয়া যায়। ফ্রন্ট অফিসের পরিদর্শক 540-662-1108 এ কল

SHENANDOAH ONCOLOGY
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Nicholas W. Gemma, M.D. Richard M. Ingram, M.D. • William A. Houck, III, M.D. • Lee P. Resta, M.D. Lindsey M. O'Brien, M.D. • M. Page Jones, M.D.
Rodney Huff, MSN, FNP-BC • Jonathan Hanson, MSN, FNP-BC
Risa Barton, MSN, FNP-BC • Kim Applegate, MSN, FNP-BC
Laurie Hudson, MSN, FNP-BC • Kendra Atherton, FNP-BC
540-662-1108 Fax: 540-667-3408

CONSENT TO TELEMEDICINE

By signing this document, you have agreed to receive care using telemedicine. Telemedicine enables health care providers at a different location than yourself to provide safe, effective, and convenient care using technology. There are risks associated with the use of telemedicine, including equipment failure and information security issues. You also understand that we cannot physically examine you.

We at Shenandoah Oncology often prefer face-to-face visits with our patients, however, sometimes the use of telemedicine is safer and more convenient; for example, in the event of an illness, COVID-19, inclement weather, etc.

By signing this document, you agree that you have access to a smart device with video and audio capabilities (such as a tablet, desktop computer, or smartphone) for the telemedicine visit.

Our providers are licensed in Virginia, so by signing this you are agreeing to accurately report your location for the telemedicine visit, which must be in Virginia.

By signing this you endorse understanding the potential risks of telehealth to include, but not limited to, distortion of images resulting from electronic transmission issues, delays in evaluations/treatments due technical difficulties or interruptions, unauthorized access to my information, or loss of information due to technical failures. I will not hold Shenandoah Oncology accountable for such issues or sequelae.

I also endorse understanding that my providers rely on the information provided by me in our telemedicine visit and that I must provide updated/accurate information about my current and past medical history.

If you are determined to be eligible for a telehealth visit, you will be provided information on how to log on to the platform. The use of this platform helps to protect your health information.

_____ _____

Signature of patient or representative Date

_____

Printed name of patient of representative

Telehealth FAQs

What is telehealth?

- Telehealth is a way to visit with a healthcare provider using technology.
- You can talk to your provider from any place, including your home.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- You use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different.
- You will not have a full physical exam during a telehealth visit.
- Your provider may decide you still need an office visit in person in our office.
- Technical problems may interrupt or stop your visit before you are done (see consent for additional risks).

Will my telehealth visit be private?

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

- There is a very small chance that someone could use technology to hear or see your telehealth visit.

How much does a telehealth visit cost?

- What you pay depends on your insurance, but a telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.