

PEDIATRIC ENVIRONMENTAL MEDICINE CENTER

PEMC

Children's Hospital of Pittsburgh of UPMC

- Free asthma screening, care, and education
- Children of all ages
- Ronald McDonald Care Mobile parked at Dickson School in Swissvale
- Every Tuesday from 9:30 A.M to 2:00 P.M.
- Primary Care for children available for physicals and immunizations
- Questions about asthma care? Call 412-692-LUNG
- Questions about primary care? Call 412-692-7777

Services will begin Tuesday, February 2, 2010



HEALTH PARTNERSHIP CONSENT
CHILDREN'S HOSPITAL OF PITTSBURGH OF UPMC
RONALD McDONALD CARE MOBILE
 412-692-7777
 Parent Consent for Health Services

Patient
Name

Medical Record
Number

Birthdate

Form CHR0400 12/08

CONSENT MEDICAL INFORMATION

I give consent for my daughter/son, _____

born on _____ to receive the services at the Care Mobile.

Patient's Primary Care Physician _____

- These services are provided by Children's Hospital of Pittsburgh of UPMC.
 Please check any of these services that you **do not** wish to be provided for your child.
- Physician Exams—Routine drivers licensure, work, camp, college, sports, school
 - Diagnosis of and treatment of illness and injuries
 - Management of chronic illnesses
 - Immunizations
 - Preventative screening and health education services

(Specifically for Pulmonology Pediatric Patients Only)

- Physical Exams
- Screening and Diagnosis of asthma and other associated conditions
- Pulmonary Function Testing both before and after administration of albuterol to determine the severity of asthma
- Referrals to specialty care for other chronic illness
- Preventive Screening and health education services
- Asthma education

Please list any allergic reactions to medicine _____

Current medications _____

Medical History including prematurity _____

Hospitalization due to breathing problems/pneumonia _____

Emergency room visits due to breathing problems _____

PERMISSION RELEASE

I understand that the confidentiality of the patient's medical record is required by law, and the record will not be released to any person or entity without prior written permission, except as otherwise authorized by law.

This Ronald McDonald Care Mobile is made possible by a grant from the Ronald McDonald House Charities, Inc., a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

AUTHORIZED SIGNATURES

Name of Parent/Legal Guardian Signing Authorization (Print) _____ Home Phone # _____ Business Phone # _____

Parent/Guardian Birth Date _____

Other Parent/Legal Guardian If Applicable _____ Home Phone # _____ Business Phone # _____

Address of Student (#, Street, Zip Code) _____

Signature of Parent/Legal Guardian _____ Date _____



0400



CLINICAL QUESTIONNAIRE
Pediatric Environmental Medicine Center

PATIENT'S NAME
MED REC NUMBER
BIRTH DATE
DATE OF SERVICE

Please fill in the blocks (PRINT) and check appropriate boxes below:

① REASON FOR VISIT:

- NEW VISIT
- FOLLOW-UP VISIT

② HAS THE PATIENT BEEN ADMITTED TO A HOSPITAL ?

YES NO

IF YES: DATE: ___/___/___ WHERE: _____ REASON: _____

③ HAS THE PATIENT BEEN SEEN IN AN EMERGENCY DEPARTMENT ?

YES NO

IF YES: DATE: ___/___/___ WHERE: _____ REASON: _____

④ Recent cold or viral illness causing breathing problems

YES NO

IF YES, When Date: _____

⑤ SOCIAL

PLEASE CHECK [✓] ALL THAT APPLY:	
CHILD LIVES WITH:	<input type="checkbox"/> PARENTS <input type="checkbox"/> GRANDPARENTS <input type="checkbox"/> GUARDIAN
PARENTS ARE:	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> OTHER:
SIBLINGS:	<input type="checkbox"/> BROTHER(S) #: _____ Ages: _____ <input type="checkbox"/> SISTER(S) #: _____ Ages: _____
<input type="checkbox"/> WORKING	<input type="checkbox"/> SCHOOL
<input type="checkbox"/> AT HOME	

⑥ ENVIRONMENT

PLEASE CHECK [✓] ALL THAT APPLY:		
<input type="checkbox"/> HOUSE	<input type="checkbox"/> CARPET IN BEDROOM	<input type="checkbox"/> MOLD
<input type="checkbox"/> APARTMENT	<input type="checkbox"/> CARPET IN HOUSE	<input type="checkbox"/> DUST
<input type="checkbox"/> MOBILE HOME		
TYPE OF HEAT:	<input type="checkbox"/> BASEBOARD	<input type="checkbox"/> GAS
	<input type="checkbox"/> ELECTRIC	<input type="checkbox"/> OTHER:
<input type="checkbox"/> PETS: _____		
<input type="checkbox"/> CIGARETTE SMOKERS IN HOUSE		
# OF SMOKERS: _____ / WHERE SMOKING? _____		

⑦ Exposure to illness

PLEASE CHECK [✓] ALL THAT APPLY:	
<input type="checkbox"/> H1N1	(date)
<input type="checkbox"/> Influenza	(date)
<input type="checkbox"/> Other	(date)
<input type="checkbox"/> Whooping cough	(date)

⑧ Medications Currently Taken (including as needed and over the counter)

NAME	DOSE	FREQUENCY	START DATE / STOP DATE

CLINICAL QUESTIONNAIRE - ASTHMA CENTER CAREMOBILE - continued

9 REVIEW OF SYSTEMS: (Please check ALL that apply)

SKIN	
<input type="checkbox"/>	Rash
<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Birth Mark
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Other: _____

HEAD	
<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Vision Problem
<input type="checkbox"/>	Watery / Red Eyes
<input type="checkbox"/>	Nasal Congestion
<input type="checkbox"/>	Polyyps in Nose
<input type="checkbox"/>	Sinus Infection
<input type="checkbox"/>	Nosebleed
<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	Tube Placement
<input type="checkbox"/>	Hearing Problem
<input type="checkbox"/>	Mouth or Lip Sores
<input type="checkbox"/>	Other

KIDNEYS / URINARY	
<input type="checkbox"/>	Urinary Infection
<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	Painful / Frequent Urination
<input type="checkbox"/>	Drinks fluids frequently
<input type="checkbox"/>	Lower Back Pain
<input type="checkbox"/>	Genital infection
<input type="checkbox"/>	Discharge
<input type="checkbox"/>	Sexually active
<input type="checkbox"/>	Menstrual Period
	-Age of onset: _____
<input type="checkbox"/>	-Problems? _____
<input type="checkbox"/>	Other: _____

NERVOUS SYSTEM	
<input type="checkbox"/>	Seizures / Convulsions
<input type="checkbox"/>	Twitching
<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Confusion
<input type="checkbox"/>	Clumsiness
<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	Other: _____

Sleep	
<input type="checkbox"/>	Snoring/apnea
<input type="checkbox"/>	Restless sleeping
<input type="checkbox"/>	Sleep walking/talking

CHEST	
<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	Tires out easily
<input type="checkbox"/>	Fast Heart Rate
<input type="checkbox"/>	Turns blue
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Feeding / Choking Problems
<input type="checkbox"/>	Cough
<input type="checkbox"/>	Phlegm or Mucus
<input type="checkbox"/>	Wheezes
<input type="checkbox"/>	Loud or Raspy Breathing
<input type="checkbox"/>	Croup
<input type="checkbox"/>	Fast Breathing
<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	Other: _____

MUSCLES / BONES	
<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Pain with Movement
<input type="checkbox"/>	Broken Bones
<input type="checkbox"/>	Joint Swelling / Pain
<input type="checkbox"/>	Limp
<input type="checkbox"/>	Curve to Back (Scoliosis)
<input type="checkbox"/>	Leg Swelling
<input type="checkbox"/>	Other: _____

GASTROINTESTINAL	
<input type="checkbox"/>	Stomachaches
<input type="checkbox"/>	Indigestion / Heartburn
<input type="checkbox"/>	Gas
<input type="checkbox"/>	Trouble Swallowing
<input type="checkbox"/>	Gags easily
<input type="checkbox"/>	Vomits often
<input type="checkbox"/>	Has "Reflux"
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Abnormal Bowel Movements
<input type="checkbox"/>	Other: _____

IMMUNE SYSTEM	
<input type="checkbox"/>	Frequent Infections
<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Other: _____

<input type="checkbox"/>	Hyper behavior
<input type="checkbox"/>	Always tired/ falls asleep during the day
<input type="checkbox"/>	Difficult to awaken/ unrested in the morning



Patient Name

CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS; RONALD McDONALD CARE MOBILE

Medical Record Number

Form CHP0394 12/08

DATE / /

Birthdate

CHILDREN'S HOSPITAL OF PITTSBURGH (CHP)/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC) CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS (TO)

CONSENT TO MEDICAL CARE

- 1. I, _____ (print or type name) consent to the provisions of care that may include diagnostic procedures, medical treatment and/or admission to the CHP/UPMC, which my/my child's attending physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for procedures involving entry into my/my child's body. If I have a religious objection to specific care to be provided I may ask CHP/UPMC not to provide such care.
2. I understand that my/my child's care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my/my child's care and/or by CHP/UPMC for education.
3. I understand and agree that others, under the direction of a physician, may assist or participate in providing hospital and/or medical care to me/my child at CHP/UPMC teaching facilities. These people may include but not limited to residents, fellows, and medical/nursing students.
4. I give CHP/UPMC and its designees permission to use my/my child's medical information as described in the CHP/UPMC Notice of Privacy Practices.
5. If applicable, I give CHP/UPMC permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my/my child's body. Once disposed of these specimens/tissue cannot be retrieved. I understand and agree that CHP/UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows CHP/UPMC to use specimens/tissue for research purposes without my/my child's authorization if my/my child's identity is not linked to the specimens/tissue. I will be asked to provide authorization for use of my/my child's specimens/tissue in research if my/my child's identity is linked to the specimens/tissue.
6. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment. Results of any examination and/or treatment are kept confidential.

I have read this Consent to Medical Care section or have had it read to me, and it has been explained to my satisfaction. [Verbal consent by the parent/guardian/patient requires two witness signatures below.]

Table with 3 columns: Signature, Date, Signature of CHP/UPMC Representative. Includes patient and witness signatures.

Relationship to patient

RELEASE OF INFORMATION

- I agree to the following terms related to release of information for services provided by CHP/UPMC and affiliates. Information related to mental health and drug and alcohol treatment requires specific consent - see number 5 below.
1. I authorize CHP/UPMC to release medical or other information required by my/my child's insurer, other payors and their agents, government agencies or their designees for review of the care provided to me/my child.
2. I have been provided the CHP/UPMC Notice of Privacy Practices. I also understand that additional copies of this Notice are available for my/my child's review upon request. Parent/Guardian/Patient initials (required)
3. I consent to access by any CHP/UPMC affiliate (including CHP/UPMC hospitals, staff, physicians providing services to me/my child and other entities and programs) to medical or other information maintained on electronic information systems or stored in various forms at individual CHP/UPMC affiliates related to treatment and/or services provided to me/my child by CHP/UPMC or any affiliate in connection with my/my child's care, health care operations or payment for treatment and services. I also authorize information related to my/my child's care to be provided to my/my child's primary care/family physician(s) and as otherwise necessary for referrals, consultation, treatment and/or other treatment related health care services to me/my child.
4. I understand that my/my child's information may be released if required by local, state or federal law.
5. For Mental Health and Drug and Alcohol Patients Only. I authorize the release of my/my child's mental health and/or drug and alcohol treatment information to government agencies or their designees for review of the care provided. Additionally, with respect to any drug and alcohol related information, disclosure of such information about me/my child shall be restricted to whether or not I/my child am/is in treatment, my/child prognosis, the program structure treatment model and services offered to me/my child, a brief description of my/child progress and a short statement as to whether I/my child have/has relapsed into drug and alcohol abuse and the frequency of any such



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releases and other information permitted under 4 Pa. Code Section 255.5(b). I understand that I have the right to revoke this permission at any time by notifying the CHP/UPMC entity where I had provided such permission.

Parent/Guardian/Patient Signature (required if applicable)

MEDICARE CERTIFICATION (IF APPLICABLE)

certify that the information given to me/my child in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me/my child to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my/my child's behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me/my child.

MEDICAID CERTIFICATION (IF APPLICABLE)

certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws. Acknowledgment of receipt - my/my child's signature acknowledges my/my child's receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS / CHAMPVA) and does not waive any of my/child's rights to request a review.

PATIENT VALUABLES

relieve CHP/UPMC of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I/my child decide(s) to keep with me/my child while I/my child am/is a patient, I/my child further understand that CHP/UPMC will not be responsible and will not replace any property lost, broken, or stolen, which I/my child decide(s) to keep with me/my child, or any property brought to me/my child while I/my child am/is a patient.

AGREEMENT TO MEDIATE CLAIMS

By initialing below, I agree that any claim which may result from the care provided to me/my child by the doctors, nurses and other health care providers in any CHP/UPMC facility shall be subject to the laws of Pennsylvania. I also agree that before any lawsuit is filed related to the care provided to me/my child, I must attempt to resolve any claim through mediation, which must take place in the Commonwealth of Pennsylvania. I am not waiving my/my child's right to a jury trial. Mediation is a process in which a neutral third person tries to help settle a claim. This agreement is binding on me/my child and any person making a claim on my/my child's behalf.

Parent/Guardian/Patient Initials: _____ (optional)

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____

_____, I am entitled under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person.

Patient Initials (required if completing this section)

I have read this Release of Information section or have had it read to me, and it has been explained to my satisfaction.

Patient Signature	Date	Signature of CHP/UPMC Representative
Signature/identity on behalf of patient/relationship	Date	Signature of CHP/UPMC Representative
Name		

FOR OFFICE USE ONLY

Patient Name: _____ Account Number: _____ MR Number: _____

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices _____

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices _____

Previously Received Refused Other: _____

If parent/guardian is not with patient at time of registration:

I acknowledge that CHP/UPMC provided to me a Notice of Privacy Practices and Consent form for me to deliver to the parent/guardian of the child listed above on _____ (date)

Signature: _____

Name: _____ (print) Relationship to Minor: _____