Monarch Wound Care

Patient Intake Form

Patient Information

Name: _____ Date of Birth: _____/_____/_____

Sex: Male Female Other: _____ Phone Number: (_____) _____

Home Address: _____

City/Town: _____ State: _____ Zip Code: _____

Insurance Type: _____ **Primary Care Physician**: _____

Any allergies we need to be aware of? Yes No

If yes, please list: _____

Height: _____ ft _____ in Weight: _____ lbs.

Reason for today's visit: _____

_____

Are you experiencing any abuse? Yes No

Emergency Contact

Name: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____ Phone Number: (_____) _____

Home Address: _____

City/Town: _____ State: _____ Zip Code: _____

Wound Assessment

Current wound location: _____

How did the wound develop? _____

How long have you had this wound? _____

Please list any previous treatments for this wound: _____

Medical History

Are you currently on a blood thinner or at increased risk of bleeding? Yes No

Do you have Diabetes? Yes No

If yes, what were your blood sugar levels this morning? _____

If yes, what was your most recent A1C? _____

Do you have Kidney Disease? Yes No

If yes, are you currently on dialysis? Yes No

Have you ever had radiation or chemotherapy? Yes No

If yes, when? _____

Do you smoke? Yes No Stopped: _____

Any non-prescription or illicit drug use? Yes No

Have you experienced two or more falls within the past year? Yes No

Have you experienced any fall with injury in the past year? Yes No

Do you have pain now? Yes No

If yes, where is the pain located? _____

If yes, what is your current pain rating? (0 no pain - 10 worst pain) _____

Patient Medical History (circle all that apply):

Anemia	Heart Attack	Rheumatoid Arthritis
Arthritis	Heart Disease	Spinal Injury
Asthma	High Blood Pressure	Stroke
Cancer	HIV/AIDS	Thyroid Problems
COPD	Kidney Stones	Tuberculosis
Deep Vein Thrombosis	Liver Disease	Ulcers
Diabetes	Low Blood Pressure	Varicose Veins
Epilepsy	Mental Illness	Other: (please list)
Fibromyalgia	Multiple Sclerosis	_____
Gall Stones	Osteoporosis	_____
Gastro Intestinal Problems	Pacemaker	_____
Glaucoma	Respiratory Disease	_____

Family History

Do you have a FAMILY history of the following? Either check no or list the familial relation (ie mother, father, etc)

	None	Yes (if yes, please list family member)
Autoimmune Disease		
Bleeding Disorders		
Cancer		
Diabetes		
Heart Disease		
Hypertension		
Kidney Disease		
Lung Disease		
Stroke		
Malignant Neoplasm (skin)		
Other		

Medications

Medications	Dose	Frequency

Surgical History	Surgery	Date

Patient Name (Print): _____

Signature: _____

Date: _____

Monarch Wound Care Consent to Treat

I hereby give my informed consent for medical treatment and procedures that may be performed by Jacqueline J. Gay PT, DPT, CWS , and your ancillary staff at Monarch Wound Care LLC. This consent includes, but is not limited to, diagnostic tests, medical examinations, surgical procedures, selective procedures to debride non vital tissues, administration of medications, and any other necessary medical interventions deemed appropriate by you or your healthcare team.

I acknowledge that you have explained to me, in terms I understand, the nature of the proposed treatment, its potential benefits, and any associated risks or complications. I have been given the opportunity to ask questions and have received satisfactory answers regarding my concerns. I understand that no guarantee of results or outcomes can be made, and unforeseen circumstances may necessitate the modification of the treatment plan.

I am aware that alternative treatment options may exist and that it is my right to seek a second opinion or explore alternative treatments. However, after considering the available information and discussing my options with you, I have chosen to proceed with the treatment plan as recommended by you.

I understand that the medical records pertaining to my treatment will be kept confidential, except as required by law or in the event of a medical emergency. I authorize the release of my medical records to other healthcare providers involved in my care, as necessary.

I further acknowledge that I am responsible for the payment of medical services rendered and agree to comply with the financial policies of [Medical Facility Name]. I understand that any applicable insurance coverage will be billed, but I am ultimately responsible for any outstanding balances.

I have read this consent form in its entirety or have had it read and explained to me, and I understand its contents. I have had an opportunity to ask questions, and my questions have been answered satisfactorily. By signing below, I acknowledge my consent to treatment.

Signature: _____

Monarch Wound Care Photography Consent

I hereby give my consent to Monarch Wound Care LLC, its healthcare professionals, and authorized representatives, to take photographs of my wounds for the purpose of monitoring and assessing the progress of my wound healing. I understand that these photographs may be used solely for medical purposes, such as documentation, analysis, and treatment planning.

I acknowledge and understand the following:

1. Purpose of Photographs: The purpose of taking these photographs is to monitor the progression of my wounds and to aid in the appropriate assessment of my wound healing. These photographs will be used for medical purposes only.

2. Confidentiality: I understand that my privacy is important and that Monarch Wound Care LLC will take all necessary measures to protect the confidentiality and security of the photographs taken. The photographs will only be accessed by authorized healthcare professionals directly involved in my care.

3. Potential Uses: The photographs may be used for the purpose of medical education, research, or quality improvement. However, any identifying information, such as my name, will be kept strictly confidential and will not be disclosed without my explicit consent, except as required by law.

4. Voluntary Participation: I acknowledge that the decision to participate in this wound monitoring program is entirely voluntary. I understand that I have the right to refuse or withdraw my consent at any time without affecting my current or future medical treatment.

5. Duration of Consent: This consent shall remain valid until I revoke it in writing or verbally.

6. Revoking Consent: If I decide to revoke my consent, I understand that it may not be possible to continue monitoring my wounds through photographs, and alternative methods of wound assessment may be required.

7. Limitations: I acknowledge that the photographs may not capture all aspects of my wound condition and that they should be used in conjunction with other medical assessments to form a comprehensive evaluation.

By signing below, I confirm that I have read and understood the information provided above. I have had the opportunity to ask questions and have received satisfactory answers. I willingly consent to the taking of photographs of my wounds for monitoring purposes by Monarch Wound Care LLC.

Patient's Signature: _____

Monarch Wound Care HIPPA Authorization Form

I hereby authorize the disclosure and use of my protected health information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. This authorization allows the release of my PHI to the individuals or organizations listed below, as necessary, to carry out the purposes specified herein.

Patient Information:

Full Name (print) _____

Date of Birth _____

Address _____

Phone Number_____

Recipient Information:

Name: _____

Name: _____

Name: _____

Name: _____

I understand that once my PHI is disclosed, it may be subject to re-disclosure by the recipient, and the privacy protections provided by HIPAA may no longer apply. I further understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this authorization. Revocation must be done in writing and sent to the address provided above.

I acknowledge that I have received a copy of this authorization form for my records, upon request.

Signature: _____