MEDICAL ADMISSION FORMS

INDEX

Burzynski CLINIC
First, Do No Harm!

9432 KATY FREEWAY ★ HOUSTON, TEXAS 77055
MAIN: 713-335-5697 FAX: 713-935-0649
WWW.BURZYNSKICLINIC.COM

Release of Medical Records Authorization

Attn: Medical Records Department

Hospital / Physician: _____

City and State: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Please release the following records:

☐ Pathology Reports ☐ Lab Reports ☐ Consult & Progress Notes

☐ Operation Reports ☐ H&P ☐ Radiology Reports & Images

☐ Treatment Notes ☐ Hospital Discharge Summaries

☐ Other/Comments: _____

Patient Information

_____ _____ _____
(last name) *(first name)* *(MI)*

Date of Birth: _____/_____/_____ SSN: _____ - _____ - _____

I hereby authorize and request that you release the above records to the Burzynski Clinic.

_____ _____/_____/_____
(signature) *(date)*

I _____ provide a copy of my medical records from other health care providers to the Burzynski Clinic for possible treatment. I understand that if for any reason, I decide not to be treated at the Burzynski Clinic, and do not request the return of the copies of my medical records, they will be retained by the Burzynski Clinic for 90 days.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Patient: _____

Signature_____

FAX to: THE BURZYNSKI CLINIC 713-804-7426
Direct phone: 713-335-5697 e-mail: info@BurzynskiClinic.com

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Today's date *(mm/dd/yyyy):* _____/_____/_____

I. PATIENT INFORMATION

Patient's Full Name _____
Last First MI

Date of Birth (mm/dd/yyyy) ____/____/_____ Age: _____ Sex: ☐ M ☐ F SSN _____ - ____ - _____

Address _____

City _____ State _____ Zip _____

Country _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Fax _____

E-mail _____

Alternate E-mail _____

II. IN CASE OF EMERGENCY NOTIFY

Person's Full Name _____
Last First MI

Relationship to patient _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Fax _____

E-mail _____

III. PRIMARY CARE PHYSICIAN OR OTHER PHYSICIAN WHO WILL ASSIST OUR CLINIC IN THE PATIENT'S CONTINUED CARE WHILE ON TREATMENT

Physician's name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____

IV. ORIGINAL ONCOLOGICAL (CANCER) DIAGNOSIS

Patient's age _____ Sex ☐ Male ☐ Female Height _____

Normal weight _____ ☐ kg ☐ lb Current weight _____ ☐ kg ☐ lb

Original cancer diagnosis _____ Date of diagnosis: _____

Original cancer location _____ Biopsy confirmed? ☐ yes ☐ no

Type/grade _____ Stage: _____ ***(If the patient has had a biopsy, please include the pathology report)***

Metastases (spread) site(s) _____

_____

Date of metastatic diagnosis _____

V. SURGERIES

Surgeries for original cancer ☐ yes ☐ no

Details of surgery	Dates

VI. CHEMOTHERAPY

☐ Yes ☐ No

Type, dosage, and number of treatments of each chemotherapeutic drug:

	Start Date:	Stop Date:

VII. RADIOTHERAPY

☐ Yes ☐ No

Radiation dose absorbed (RADS) _____

Area(s) radiated	Start Date:	Stop Date:

VIII. OTHER CANCER THERAPIES *(Types and last day of treatment including nontraditional therapies)*

Other therapies/drugs (past) _____

Other therapies/drugs (present) _____

_____

Hormones _____

_____

IX. PATIENT'S OVERALL CONDITION

☐ Excellent

☐ Good

☐ Fair

☐ Poor

☐ Very Poor

Is patient ambulatory? ☐ yes ☐ no ☐ Wheelchair ☐ Walker ☐ Other (describe) _____

On oxygen: ☐ yes ☐ no

Patient's overall attitude _____

X. HEALTH HISTORY (SYMPTOMS - Check symptoms you currently have)

GENERAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Decreased Activity
- ☐ Loss of sleep
- ☐ Pain *location:* _____
- ☐ Sweats
- ☐ Weight Gain:____*lbs*____*kg*
- ☐ Weight Loss:____*lbs*____*kg*

EYES
- ☐ Blurred vision
- ☐ "Cross-eyed"
- ☐ Double vision
- ☐ Light flashes
- ☐ Loss of vision
- ☐ Seeing "halos"

EARS
- ☐ Hearing loss
- ☐ Ringing in the ears

NOSE
- ☐ Airway obstruction
- ☐ Allergies
- ☐ Drainage

RESPIRATORY
- ☐ Blood in Sputum/phlegm
- ☐ Sputum/phlegm
- ☐ Cough
- ☐ Hemoptysis
- ☐ Known Tuberculosis exposure
- ☐ Pain
- ☐ Respiratory infections
- ☐ Shortness of Breath
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Blood clots
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphadenopathy *location:* _____
- ☐ Irregular heartbeat
- ☐ Poor circulation
- ☐ Swelling of extremities
- ☐ Varicose veins

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Black Stool
- ☐ Blood in Stool
- ☐ Rectal bleeding
- ☐ Gas
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Difficulty swallowing
  - ☐ Liquids
  - ☐ Solids
- ☐ Indigestion
- ☐ Nausea

GENITOURINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

NEUROLOGICAL
- ☐ Balance difficulties
- ☐ Blackouts
- ☐ Confusion
- ☐ Dizziness
- ☐ Falls
- ☐ Headaches
- ☐ Memory loss
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Abnormalities
- ☐ Tingling
- ☐ Tremors

PSYCHIATRIC
- ☐ Agitation
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Irritability
- ☐ Mood changes
- ☐ Obsessions

SKIN
- ☐ Easy bruising
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MUSCLE/JOINT/BONE
- ☐ Atrophy
- ☐ Deformity
- ☐ Limited range of motion
- ☐ Pain
- ☐ Stiffness
- ☐ Swelling

MEN ONLY
- ☐ Dribbling
- ☐ Erection difficulties
- ☐ HPV
- ☐ Lump in testicles
- ☐ Penile discharge
- ☐ Sore on penis
- ☐ Vasectomy
- ☐ Other (describe): _____

WOMEN ONLY
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ HPV
- ☐ Hot flashes
- ☐ Menstrual pain
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ PMS
- ☐ Vaginal discharge
- ☐ Other (describe) _____

Date of last menstrual period *(mm/dd/yy)*: ____ / ____ / _____

Are you pregnant? ☐ yes ☐ no

Number of children _____

Have you had a PAP Smear?
☐ Yes ☐ No
☐ Normal ☐ Abnormal

If Yes, date of last PAP Smear:
(mm/dd/yy) ____/____/_____

Have you had a Mammogram?
☐ Yes ☐ No
☐ Normal ☐ Abnormal

If Yes, date of last Mammogram:
(mm/dd/yy) ____/____/_____

XI. CONDITIONS Check conditions you have had in the past, and current conditions

Past	Current	Past	Current	Past	Current	Past	Current
☐	☐ AIDS	☐	☐ Chemical dependency	☐	☐ High cholesterol	☐	☐ Prostate problems
☐	☐ Alcoholism	☐	☐ Chicken Pox	☐	☐ HIV positive	☐	☐ Psychiatric care
☐	☐ Anemia	☐	☐ Diabetes	☐	☐ Kidney disease	☐	☐ Rheumatic fever
☐	☐ Anorexia	☐	☐ Emphysema	☐	☐ Liver disease	☐	☐ Scarlet fever
☐	☐ Appendicitis	☐	☐ Epilepsy	☐	☐ Measles	☐	☐ Stroke
☐	☐ Arthritis	☐	☐ Glaucoma	☐	☐ Migraine Headaches	☐	☐ Suicide attempt
☐	☐ Asthma	☐	☐ Goiter	☐	☐ Miscarriage	☐	☐ Thyroid problems
☐	☐ Bleeding disorders	☐	☐ Gonorrhea	☐	☐ Mononucleosis	☐	☐ Tonsillitis
☐	☐ Breast lump	☐	☐ Gout	☐	☐ Multiple sclerosis	☐	☐ Tuberculosis
☐	☐ Bronchitis	☐	☐ Heart disease	☐	☐ Mumps	☐	☐ Typhoid fever
☐	☐ Bulimia	☐	☐ Hepatitis	☐	☐ Pacemaker	☐	☐ Ulcers
☐	☐ Cancer	☐	☐ Hernia	☐	☐ Pneumonia	☐	☐ Vaginal infections
☐	☐ Cataracts	☐	☐ Herpes	☐	☐ Polio	☐	☐ Venereal disease

☐ **OTHER CONDITION(S): if checked, please explain:**

_____

_____

_____

_____

XII. MEDICATIONS – list all medications, dosages and frequency per day (prescription & non-prescription)

Medication	Dosage	Frequency

XIII. ALLERGIES –

☐ No Known Allergies

☐ Allergies to Medications or Substances list below & describe allergic reaction:

Pharmacy Name: _____ Phone Number: _____

XIV. FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following

	Disease	Relationship to you
☐	Allergies/ Hay fever	
☐	Arthritis	
☐	Asthma	
☐	Cancer	
☐	Chemical dependency	
☐	Diabetes	
☐	Gout	
☐	Heart disease	
☐	High blood pressure	
☐	High Cholesterol	
☐	Kidney disease	
☐	Stroke	
☐	Tuberculosis	
☐	Other	

XV. Hospitalization

Year	Hospital	Reason for hospitalization

Have you ever had a blood transfusion ☐ Yes ☐ No

If yes, give dates

Red blood cell transfusion _____

Platelet transfusion _____

Other transfusion

Serious illness/injury	Date	Outcome

Pregnancy history

Sex	Year of birth	Complications if any

Health habits Check which substances you use, and describe the amount and frequency of use.

	Caffeine	
	Tobacco	
	Alcohol	
	Drugs	
	Other	

Occupational concerns

Check if your work exposes you to the following

	Psychological stress
	Hazardous substances (asbestos, lead, etc.)
	Heavy lifting
	Other

Your occupation

I certify that the above information is correct of the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature _____ Date _____

Reviewed by _____ Date _____

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Patient Contact Information

Please list spouse, children, family members and friends that may be contacted on your behalf. If the patient is a minor/child, then a parent, legal guardian, or spouse must be listed as a contact.

The Burzynski Clinic may contact the following individuals to provide appointment reminders, health status inquiry or information about treatment, treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.

Patient Name: _____ ☐Adult ☐Child

(home #): _____ *(cell #):* _____ *(work #):* _____

Email: _____

Contact: _____ *(relationship)* _____

(home #): _____ *(cell #):* _____ *(work #):* _____

Email: _____

Contact: _____ *(relationship)* _____

(home #): _____ *(cell #):* _____ *(work #):* _____

Email: _____

Contact: _____ *(relationship)* _____

(home #): _____ *(cell #):* _____ *(work #):* _____

Email: _____

Contact: _____ *(relationship)* _____

(home #): _____ *(cell #):* _____ *(work #):* _____

Email: _____

I authorize and understand that information may be relayed to the following persons or whoever may answer the phone at the following numbers until this authorization is revoked.

_____ ____/____/_____
Patient Signature *Date*

_____ ____/____/_____
Parent/Legal Guardian/Spouse Signature *Date*

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1) The Burzynski Clinic is permitted to make uses and disclosures of protected health information for treatment, research, payment and health operations until this authorization is revoked, as described in the following examples:
   a) For treatment: Consultation, lab work, etc.
   b) For research: Anonymously via a patient number to the Food and Drug Administration (FDA), Independent Review Board (IRB), the sponsor of the research study and for publication.
   c) For Payment: Claim filing, collection of payment(s) due, etc.
   d) For healthcare operations: Chart maintenance, regulatory requirements, accounting, HIPAA compliance activities, etc.

2) The Burzynski Clinic is permitted or required, under specific circumstance, to use or disclose protected health information without the individual's written authorization. Other disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization at any time.

3) The Burzynski Clinic may engage in the following activities:
   a) The Burzynski Clinic may contact the individual or other immediate adult family member(s) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.

4) The individual or patient has the following rights regarding protected health information:
   a) The right to request restrictions on certain uses and disclosures of protected health information. However, the Burzynski Clinic is not required to agree to a request restriction.
   b) The right to receive confidential communications of protected health information, as applicable.
   c) The right to inspect and copy protected health information, as provided in the Privacy Regulation.
   d) The right to amend protected health information, as provided in the Privacy Regulation.
   e) The right to receive an accounting of disclosures of protected health information.
   f) The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

5) The Burzynski Clinic is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

6) The Burzynski Clinic is required to abide by the terms of the Notice currently in effect.

7) The Burzynski Clinic reserves the right to change the terms of the Notice. The new Notice provisions will be effective for all protected health information that it maintains.

8) The Burzynski Clinic will provide individuals or patients with a revised Notice as requested.

9) Individuals may complain to the Burzynski Clinic and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated.

10) The Burzynski Clinic contact person for the matter relating to complaints:

Alejandro Marquis
9432 Katy Freeway
Houston, Texas 77055
Phone: 713-335-5697

11) This Notice is first in effect on April 14, 2003.

12) The Burzynski Clinic elects to limit the use(s) and/or disclosure(s) that it is permitted to make by law.

I hereby acknowledge that I have received a copy of the Burzynski Clinic's Notice of Privacy Practices.

_____
(Print: Patient name)

_____ _____/_____/_____
(Patient Signature) *(date)*

_____ _____
(Parent / Legal Guardian / Spouse: print name) *(relationship to patient)*

_____ _____/_____/_____
(Parent / Legal Guardian / Spouse: signature) *(date)*

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Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information that is required to carry out treatment, research, payment and healthcare operations on my behalf until this authorization is revoked.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used and/or disclosed.
- I understand that the Burzynski Clinic is not required to agree with my requested restrictions. I also understand that once the Burzynski Clinic agrees to my restrictions, it must comply with those restrictions.
- I have the right to revoke my consent for the use and/or disclosure of my protected health information at any time. I understand that if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that the Burzynski Clinic must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- The Burzynski Clinic has reserved the right to change from time to time its Privacy Practices. Whenever these changes are made, it will be reflected in the Privacy Practices and I will be informed via a posted notice.

_____
(Patient: print name)

_____ _____/_____/_____
(Patient Signature) *(date)*

_____ _____
(Parent / Legal Guardian / Spouse: print name) *(relationship to patient)*

_____ _____/_____/_____
(Parent / Legal Guardian / Spouse: signature) *(date)*

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Personalized Targeted Treatment Patient Information Checklist

This checklist is to ensure that you are adequately prepared for your appointment with our Clinic. Please read and initial each line, sign at the bottom, and return to the Clinic via postal mail, email, or fax with the other applicable documents required.

_____ I was informed of the purpose of treatment.

_____ If I decide to initiate therapy, I will be asked to stay in Houston for 1-3 weeks on an outpatient basis.

_____ I have informed the Burzynski Clinic if I am in stable physical condition, mobile and able to travel, have normal liver and kidney function, and if I am able to eat and swallow.

_____ I was informed that the following medical records must be reviewed prior to scheduling an appointment:

- All pathology reports
- Oncologist/treating physician notes *(especially chemotherapy flow sheet and last dictation)*
- Operative/surgical reports
- Diagnostic reports *(CT, MRI, PET, mammography, radiography and echocardiography)*
- Laboratory reports *(most recent CBC, CMP, urinalysis and tumor markers)*
- Complete contact information of the following:
  - Referring Physician
  - Primary Care Physician
  - Oncologist/Treating Physician

I have read the information packet sent to me and I fully understand my obligations.

Patient's Name*(print)*: _____

Patient's Signature: _____ Date: _____/_____/_____

Parent/Legal Guardian
or Spouse's Name*(print)*: _____

Parent/Legal Guardian
or Spouse's Signature: _____ Date: _____/_____/_____