HEALING HANDS OF LYMPHATICS

PATIENT INFORMATION

UE:_____LE:_____

Date of Evaluation___/___/___ **D.O.B.**_____ **Sex: M / F**
Age _____ **Weight**_____

Last Name_____ **First** _____ **MI**_____

Address _____ **Apt#**_____

City_____ **State** _____ **Zip** _____

Home# _____ **Work#** _____ **Cell#** _____

Email Address: _____

In case of Emergency Call: _____ **Phone:**_____

Whom may we thank for referring you to us? _____
Please Circle: Friend Doctor Nurse Internet Article

Referring Physician: _____ **Phone:** _____

Are you Receiving Home Health Nursing care now or in the past 3 months? Yes or No

Name of Agency_____ **Contact**_____ **Phone**_____

Social Security#:_____

Insurance Name:_____

ID# _____ **Group#**_____

Medicare ID#:_____

Supplemental Name: _____

ID#:_____ **Group#:**_____

Your Chief Complaint: _____
(Or area requiring Treatment)
Circle Problem areas: Arm R/L Legs R/L Chest Back Face Neck Trunk/Body Buttocks

Diagnosis1:_____ **2:**_____

When did your lymphedema/swelling begin? _____

What caused the swelling?_____

(OVER)

Primary Physician: _____ Please List any other doctors involved in your care:

Podiatrist: _____ _____

Oncologist: _____ _____

Surgeon: _____ _____

Radiation Oncologist: _____

Dermatologist: _____

Orthopedist: _____

Plastic Surgeon: _____

Cardiologist: _____

List ALL Medications, Chemo and/or Vitamins: _____

_____

_____

List Any Surgeries and Dates: _____

_____

_____

_____

_____

_____

Lymph Nodes removed? Yes / No How Many? _____ + Nodes_____ - Nodes_____ Dates: _____

Radiation Therapy? Yes / No How many treatments? _____ Dates: _____

Please list areas Radiated: _____

Past Medical History:

___Alzheimer's
___Arthritis Rhematoid/Osteo
___Aneurysm
___Cardiac
___CHF
___Diabetes
___Hepatitis
___Thyroid Hypo/Hyper
___HTN
___Pulmonary
___Renal
___DVT
___Pacemaker
___Stroke-CVA
___Multiple Sclerosis
___Parkinson's Disease

Other: _____

_____

_____

_____

___Cellulitis Where/Date: _____

___Cancer-list type: _____

I understand coverage has been verified by my insurance company. I also understand that any charges Incurred, that are my responsibility as directed by my insurance will be paid by me to Healing Hands of Lymphatics Plus LLC, upon receiving payments from primary or supplemental insurance. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that all the information is true and correct to the best of my Knowledge.

Signature: _____ Date: _____