Cancer Care

Welcome to HonorHealth Cancer Care. Our valley-wide locations put you, the patient, at the center of everything we do. Our team of specialists are committed to providing you with outstanding coordinated care.

Prior to your visit

Before your appointment, we ask that you print and fill out the attached New Patient Packet. We realize that you may have already provided similar information to other HonorHealth providers in the past and understand that this may seem redundant. However, with health histories and circumstances changing continually, it is important for our team to have your most recent and updated information to provide you with the finest personalized care.

MyChart App

To simplify your healthcare, we strongly encourage you to download or sign up for the MyChart App. MyChart is a free, easy-to-use, secure website that gives you access to your health information quickly and conveniently from your computer, smartphone or tablet. Visit HonorHealth.com/mychart to learn more about the advantages of MyChart and to get instructions on how to sign up.

If you have questions, please do not hesitate to talk to your physician. You may also call 855-485-HOPE (4673) for additional information and support.

It is an honor to serve you during this time.

HONORHEALTH®

PATIENT REGISTRATION

Hematology/Medical and GYN Oncology Division

Patient Full Name: _____ **Birth Date:** _____

SSN: _____ **Email Address:** _____ **Gender**: ☐ M ☐ F

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone: _____ **Work phone**: _____

Mobile Phone: _____ **Mobile Phone Provider**: _____

Notification preference? ☐ Mobile Phone ☐ e-Mail ☐ Text Message ☐ Home Phone

May we leave a message (circle)? Yes or No **Please circle preference for voice message**: Home or Mobile Phone

Mothers Maiden Name: _____

Emergency Contact: _____ **Relationship to Patient**: _____

Home Phone: _____ **Mobile Phone**: _____

Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino (requested demographic question for the State of AZ)

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ White/Caucasian
☐ Native Hawaiian ☐ Other Pacific Islander ☐Other: _____

Religion Preference: _____

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other: _____

Visually Impaired: ☐ Yes ☐ No

Patient Employer: _____ **Occupation:** _____

Primary Insurance: _____ **Subscriber Name**: _____

Subscriber Date of Birth: _____ **Relationship to Subscriber**: _____

ID# _____ **Group#:** _____

Secondary Insurance: _____ **Subscriber Name**: _____

Subscriber Date of Birth: _____ **Relationship to Subscriber**: _____

ID# _____ **Group#**: _____

Do you have a Living Will? ☐ Yes ☐ No **If yes, please provide a copy for our records**
Do you have a DNR? ☐ Yes ☐ No **If yes, please provide a copy for our records**

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PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

Visit Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ When did the problem begin: _____

REFERRING DOCTOR (NAME, ADDRESS, PHONE #) _____

PRIMARY DOCTOR (NAME, ADDRESS, PHONE #) _____

PATIENT'S PHARMACY (NAME, ADDRESS, PHONE #) _____

MEDICINE/FOOD/LATEX/CONTRAST ALLERGIES:___ NONE or LIST IF ANY: _____

CURRENT MEDICATIONS (name and dosage) OR **CHECK HERE** _____ if Med List is attached

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

CHRONIC CONDITIONS/PAST MEDICAL HISTORY: Have you ever had any of the following? (circle all that apply)

High Blood Pressure
Diabetes – If yes, type: _____
Stroke/TIA
Lupus
Heart Failure
Vascular Disease
Heart Disease
Heart attack
Seizures
Colitis/Diverticulitis
Anxiety
Depression
COPD
Hyperthyroidism
Abnormal Heart Rhythm
Atrial Fibrillation
Heart Murmur
Neuropathy
Hypothyroidism
Aneurysm
Blood Clots
Genetic Disorder Type: _____
STDs - If yes, type: _____
HIV
Other: _____

Have you had any of the following tests?

	Yes	When and Where
Abnormal biopsy	☐	
CT Scan	☐	
MRI Scan	☐	
PET Scan	☐	
Mammogram	☐	
Colonoscopy	☐	
PAP Smear	☐	
Endoscopy	☐	
Blood Transfusions	☐	
Bone Mineral Density Test (DEXA)	☐	

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PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

Patient Name: _____ Date of Birth: _____

PATIENT SURGICAL HISTORY (NAME AND YEAR)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Any implanted devices or metal (pacemakers, pumps, etc.) Please circle: YES NO

VACCINES: Have you had the following vaccines:

PNEUMONIA ☐ NO ☐ YES, Date _____ **TETANUS** ☐ NO ☐ YES, Date _____
SHINGLES ☐ NO ☐ YES, Date _____ **FLU VACCINE** ☐ NO ☐ YES, Date _____
OTHER VACCINE ☐ NO ☐ YES, Date _____

TOBACCO USE: ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **ALCOHOL USE:** ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY
CAFFEINE (Coffee, tea, energy drinks) ☐ NEVER ☐ RARELY ☐ DAILY
DRUG USE: ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **EXPOSURE TO HIV:** ☐ NO ☐ YES

SOCIAL HISTORY: Lifestyle

Highest Education level: _____
With whom do you live? _____
Do you exercise? ☐ Never ☐ Sometimes ☐ 30 minutes, 3x/week or more
Have you experienced 10 lbs weight loss or gain in past 3 months? ☐ NO ☐ YES

SOCIAL HISTORY: Mobility

Do you have problems with mobility (use a wheelchair, cane, or walker)? ☐ NO ☐ YES; if yes describe issue and/or device used: _____
Have you had a fall in the past year? ☐ NO ☐ YES
Do you feel unsteady? ☐ NO ☐ YES

FAMILY MEDICAL HISTORY

	ALIVE AND WELL?	**DISEASE**	**IF DECEASED, CAUSE AND AGE OF DEATH**
FATHER	☐ NO ☐ YES		
MOTHER	☐ NO ☐ YES		

Any history of cancer in the family? _____

Are there any religious considerations that would keep you from receiving blood products? ☐ NO ☐ YES

Women only ---

Age menstrual cycle began: _____ **Menopause Age:** _____ **Number of Pregnancies:** _____ **Live Births:** _____

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Hematology/Medical Oncology and GYN Oncology Division

CONSTITUTIONAL SYMPTOMS		
ACTIVITY CHANGE	NO	YES
APPETITE CHANGE	NO	YES
CHILLS	NO	YES
DIAPHORESIS (SWEATING)	NO	YES
FATIGUE (WEAKNESS)	NO	YES
FEVER	NO	YES
NIGHT SWEATS	NO	YES
PAIN	NO	YES
RIGORS (CHILLS)	NO	YES
UNEXPECTED WEIGHT CHANGE	NO	YES
HEENT		
CONGESTION	NO	YES
DENTAL PROBLEM	NO	YES
DRY MOUTH	NO	YES
EAR PAIN	NO	YES
FACIAL SWELLING	NO	YES
HAIR LOSS	NO	YES
HEARING LOSS	NO	YES
MOUTH SORES	NO	YES
NOSEBLEEDS	NO	YES
POSTNASAL DRIP	NO	YES
RHINORRHEA (RUNNY NOSE)	NO	YES
SINUS PRESSURE	NO	YES
SORE THROAT	NO	YES
TASTE CHANGES	NO	YES
THRUSH	NO	YES
TINNITUS (RINGING IN EARS)	NO	YES
TROUBLE SWALLOWING	NO	YES
VOICE CHANGE	NO	YES
BREAST		
RIGHT INVERTED NIPPLE	NO	YES
RIGHT MASS	NO	YES
RIGHT NIPPLE DISCHARGE	NO	YES
RIGHT SKIN CHANGE	NO	YES
LEFT INVERTED NIPPLE	NO	YES
LEFT MASS	NO	YES
LEFT NIPPLE DISCHARGE	NO	YES
LEFT SKIN CHANGE	NO	YES
EYES		
BLURRED VISION	NO	YES
DOUBLE VISION	NO	YES
EYE DISCHARGE	NO	YES
EYE ITCHING	NO	YES
EYE PAIN	NO	YES

EYES CONTINUED		
EYE REDNESS (DRY EYES)	NO	YES
FLOATERS	NO	YES
PHOTOPHOBIA (SENSITIVITY TO LIGHT)	NO	YES
VISUAL DISTURBANCE	NO	YES
RESPIRATORY		
DYSPNEA ON EXERTION (SHORTNESS OF BREATH ON EXERTION)	NO	YES
CHEST TIGHTNESS	NO	YES
CHOKING	NO	YES
COUGH	NO	YES
HEMOPTYSIS(COUGHING UP BLOOD)	NO	YES
SHORTNESS OF BREATH (DIFFICULTY BREATHING)	NO	YES
STRIDOR	NO	YES
WHEEZING (ASTHMA)	NO	YES
CARDIOVASCULAR		
CHEST PAIN	NO	YES
LEG SWELLING	NO	YES
ORTHOPNEA	NO	YES
PALPITATIONS	NO	YES
PND(PAROXYSMAL NOCTURNAL DYSPNEA)	NO	YES
GI		
ABDONIMAL DISTENTION	NO	YES
ABDOMINAL PAIN	NO	YES
ANAL BLEEDING	NO	YES
ASCITES (ABDOMINAL SWELLING)	NO	YES
BLOOD IN STOOL (BLACK STOOLS)	NO	YES
CONSTIPATION	NO	YES
DIARRHEA	NO	YES
EARLY SATIETY (FEELING FULL)	NO	YES
GERD/HEARTBURN	NO	YES
NAUSEA AND VOMITING	NO	YES
HERNIA	NO	YES
ENDOCRINE		
COLD INTOLERANCE	NO	YES
DIABETES	NO	YES
HEAT INTOLERANCE	NO	YES
HOT FLASHES	NO	YES
POLYDIPSIA (GREAT THIRST)	NO	YES
POLYPHAGIA (EXCESSIVE EATING)	NO	YES
POLYURIA (EXCESSIVE URINATION)	NO	YES
PRE-DIABETES	NO	YES
GU		
DYSURIA((PAIN/DIFFICULTY URINATING, HESITANCY)	NO	YES
FLANK PAIN	NO	YES

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PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

GU CONTINUED				PSYCHIATRIC		
FREQUENT URINATION	NO	YES		AGITATION	NO	YES
HEMATURIA (BLOOD IN URINE)	NO	YES		BEHAVIOR PROBLEM	NO	YES
INCONTINENCE	NO	YES		CONFUSION	NO	YES
NOCTURIA (FREQUENT URINATION AT NIGHT)	NO	YES		DECREASED CONCENTRATION	NO	YES
PENILE DISCHARGE	NO	YES		DEPRESSION	NO	YES
PENILE PAIN	NO	YES		HALLUCINATIONS	NO	YES
PENILE SWELLING	NO	YES		HYPERACTIVE	NO	YES
SCROTAL SWELLING	NO	YES		NERVOUS/ANXIOUS (PANIC ATTACKS)	NO	YES
TESTICULAR PAIN	NO	YES		SELF-INJURY	NO	YES
URGENCY TO URINATE	NO	YES		SLEEP DISTURBANCE (INSOMNIA)	NO	YES
DECREASED URINE	NO	YES		SUICIDAL IDEAS	NO	YES
MUSCULOSKELETAL				HOMICIDAL IDEAS	NO	YES
ARTHRALGIAS (JOINT PAIN/BONE PAIN)	NO	YES		**GYN**		
BACK PAIN	NO	YES		VAGINAL DISCHARGE	NO	YES
GAIT PROBLEM (WALKING ABNORMALLY)	NO	YES		VAGINAL PAIN	NO	YES
JOINT SWELLING	NO	YES		ABNORMAL BLEEDING	NO	YES
MYALGIAS (MUSCLE PAIN)	NO	YES				
NECK PAIN	NO	YES				
NECK STIFFNESS	NO	YES				
SKIN						
BLISTERING	NO	YES				
CHANGING MOLES (SKIN LESIONS)	NO	YES				
COLOR CHANGE	NO	YES				
ALLERGY/IMMUNE SYSTEM						
ENVIRONMENTAL/SEASONAL ALLERGIES	NO	YES				
FOOD ALLERGIES	NO	YES				
IMMUNOCOMPROMISED	NO	YES				
CHEMICALS IN WORKPLACE	NO	YES				
NEUROLOGICAL						
PAINFUL NEUROPATHY	NO	YES				
DIZZINESS	NO	YES				
FACIAL ASYMMETRY	NO	YES				
HEADACHES	NO	YES				
LIGHT-HEADEDNESS	NO	YES				
NUMBNESS/TINGLING	NO	YES				
SEIZURES	NO	YES				
SPEECH DIFFICULTY	NO	YES				
SYNCOPE (ALTERED CONSCIOUSNESS)	NO	YES				
TREMORS	NO	YES				
WEAKNESS (PARALYSIS)	NO	YES				
HEMATOLOGIC						
ADENOPATHY (ENLARGED GLANDS)	NO	YES				
BRUISES/BLEEDS EASILY	NO	YES				
LYMPHEDEMA	NO	YES				
PETECHIAE (BLEEDING UNDER SKIN)	NO	YES				
PURPURA (RASH)	NO	YES				

HONORHEALTH®
Cancer Care

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Healthcare Provider: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑ Y ☐ N	*EXAMPLE BREAST CANCER*	45	——	—	Aunt Cousin	45 51	Grandmother	53
☐ Y ☐ N	BREAST CANCER *(Female or Male)*							
☐ Y ☐ N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐ Y ☐ N	UTERINE (ENDOMETRIAL) CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME GASTROINTESTINAL POLYPS *(Specify #)*							
☐ Y ☐ N	OTHER CANCER(S) *(Specify cancer type)*	*Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had generic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	o **2 or more:** breast / ovarian / prostate / pancreatic cancer o **2 or more:** colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) o **2 or more:** melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger:**	o Breast cancer o Colorectal cancer o Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age:**	o Ovarian cancer o Breast: Male breast cancer or Triple negative breast cancer o Colorectal cancer with abnormal MSI/IHC, or MSI associated histology †† o Endometrial cancer with abnormal MSI/IHC o 10 or more gastrointestinal polyps*

☐ Presence of tumor infiltrating lymphocytes, Chrohn's-lick lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern * Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use only: Patient offered hereditary cancer genetic testing? YES NO ☐ ACCEPTED ☐ ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment _____

Cancer Care

Infusion Financial Counselor introduction

At HonorHealth, the last thing we want is for your care to be frustrating. One of the ways we go beyond in caring for you is by meeting with you before you begin treatment. We'll discuss costs and options that can help alleviate any unexpected financial burden of your treatment. Our financial counselors will provide you with financial information regarding your insurance benefits (including details about your deductible status and out of pocket liability), as well as our payment policies. Determining your financial needs is not a one-time exercise –our financial counselors will meet with you and your family regularly to update any changes in your insurance coverage and reevaluate your financial resources throughout your treatment plan. Since you'll be receiving infusion treatments or injections in one of our clinics, here's how our team will support you:

- Once treatment is prescribed, our authorization team will verify the authorization requirements for your insurance. Our team members will initiate the authorization process to ensure your treatment can start in a timely manner.
- Our financial counselors will reach out to you before you start treatment to explain your insurance coverage, review your benefits and discuss your estimated financial responsibility based on information provided by your insurance.
- Once your authorization has been received, our team will continue to follow your treatment to ensure that any ongoing authorization needs are addressed.
- Our financial counselors will also review any possible financial assistance options from the manufacturer (if applicable), third-party foundations and any programs available through HonorHealth.
- If your physician orders a treatment that your insurance does not authorize, we'll work with the pharmaceutical company to apply for any applicable assistance program for you. Our counselors will work with you to complete the financial assistance forms and submit them for you.

Financial counselors are available from 7:30 a.m. to 3:30 p.m., Monday-Friday to answer your questions and discuss your treatment plan.

Thank you for choosing HonorHealth. We look forward to going the extra mile for you.

Laura Luna
Manager-Patient Access
Laluna@honorhealth.com

Sonia Vivas
Supervisor-HOPD
480-534-4732
svivas@honorhealth.com

HONORHEALTH®

Cancer Care

Notice of Privacy Practices and Communication Consent

This form is to identify who may or may not have access to oral communication in regards to the patient's protected health information while the patient is under treatment.

List the full name of family or friends with whom HonorHealth Cancer Care can share your protected health information.

Name	Phone Number	Relationship

I _____ acknowledge that I have received a copy of HonorHealth Cancer Care's Notice of Privacy Practices. I have identified who may or may not have access to my protected health information while under treatment at Cancer Care Cancer Care Network.

I understand that this release is valid for the time frame of my diagnosis but may revoke authorization at any time by informing HonorHealth Cancer Care specialists and my physician.

Print Name: _____ Date: _____

Patient Signature: _____

Medical Records Release To:

HonorHealth Cancer Care
2500 W. Utopia Road, Phoenix AZ 85027

I authorize the following physician/facility to disclose information from my health record:

Physician Name _____ **Facility:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone Number: _____ **Fax Number:** _____

PATIENT IDENTIFICATION ***All information must be filled out completely to process your request***	_____ Patient Name		_____ Date of Birth
	_____ Address		_____ Phone Number
	_____ City _____ State _____ Zip		
	Dates of Service: From _____ To_____		
INFORMATION REQUESTED	0 Office Visit Note(s) 0 Laboratory Results 0 EKG Report 0 History & Physical	0 Pathology Report 0 X-Ray Reports 0 Billing Record	0 **Other:**
INFORMATION TO BE SENT TO	HonorHealth Cancer Care Email: hhcancercarechartprep@honorhealth.com Phone: 602-562-3445 Fax: 480-882-5015		

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that the practice will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. The John C. Lincoln Physician Network Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that I may receive a copy of this authorization.

Unless I revoke this authorization earlier, **it will expire one year from the date signed** or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release the practice, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient **or**
Description of Authority to Act for Patient

For Healthcare Use Only

Date Received: _____ **Date Sent:** _____ **Processor:** _____

PN 200