South Texas
Surgical Hospital
In Partnership with Physician Owners

Infectious Disease Screen

1. Are you currently experiencing any of the following?
   (Please select all that apply)
   - ☐ Fever
   - ☐ Pneumonia
   - ☐ Respiratory Infection
   - ☐ Respiratory Distress (cough, shortness of breath)
   - ☐ Headache
   - ☐ Muscle pain
   - ☐ Weakness
   - ☐ Fatigue
   - ☐ Diarrhea
   - ☐ Nausea/Vomiting
   - ☐ Stomach pain
   - ☐ Unexplained bleeding or bruising
   - ☐ Swelling of Salivary Glands or Parotid
   - ☐ General feeling of discomfort

2. Have **you**, *OR* **anyone you have been in contact with**, traveled outside of the United States within the last 30 days?

   ☐ Yes *If yes*, **Where to?** ________________________________.
   ☐ No *If yes*, **When?** ________________________________.

3. Have **you**, *OR* **anyone you have been in contact with**, been exposed to Ebola, Middle East Respiratory Syndrome (MERS), Mumps or Coronavirus in the last 30 days?

   ☐ Yes *If yes*, please circle exposure: **EBOLA MERS MUMPS CORONAVIRUS**

   ☐ No *If yes*, **When?** ________________________________.

Version: January 2020

Patient Label

South Texas Surgical Hospital
In Partnership with Physician Owners

SOUTH TEXAS SURGICAL HOSPITAL & OUTPATIENT CENTER

PATIENT INFORMATION

Admission use only

Pkt Given Time: ____________

Pkt Return Time: ____________

Hospital Time: ____________

PLEASE FILL OUT ALL BLANKS AND PRINT LEGIBLY PAT IN TIME:_________ PAT OUT TIME:_________

PATIENT DEMOGRAPHICS

1. HAVE YOU HAD A PROCEDURE HERE BEFORE? _____ YES _____NO IF YES, WHEN? ____________________
2. PATIENT (FIRST NAME): ______________ MIDDLE: ____________ LAST NAME:______________ MALE: ___ FEMALE: ___
3. ADDRESS: ______________________ CITY: ______________ COUNTY:______________
4. STATE: _____ ZIP CODE: _________ HOME PHONE NUMBER: ( ) ____________ CELL PHONE NUMBER: ( )____________
5. DATE OF BIRTH: _____/____/______ SS#:_______-______-_______ **Medicare #** ______________
6. MARITAL STATUS:(circle) MARRIED DIVORCED SINGLE WIDOWED **COUNTRY OF ORIGIN (BORN):**______________
7. NATIONALITY: ____ HISPANIC OR LATINO ____ NOT HISPANIC OR LATINO **E-MAIL ADDRESS:**______________
8. RACE: __ WHITE __ ASIAN __ BLACK __ OTHER: ____________ RELIGION: ______________
9. EMPLOYMENT STATUS: ____ EMPLOYED ____ UNEMPLOYED ____ RETIRED ____ STUDENT
10. EMPLOYER NAME: ______________ ADDRESS: ______________PHONE:____________

    OCCUPATION ______________ FT__ PT__

RESPONSIBLE PARTY

11. IS THE PATIENT UNDER THE AGE OF 18? __ YES __ NO IF YES, PLEASE COMPLETE THIS SECTION IF NO, SKIP TO INSURANCE INFORMATION SECTON
12. RESPONSIBLE PARTY NAME: ____________________ DATE OF BIRTH: ____/____/_____
13. SOCIAL SECURITY NUMBER: _____-______-_______ RELATIONSHIP TO PATIENT: ____________ Employer:______________

INSURANCE INFORMATION

14. PRIMARY INSURANCE: ______________ IS PATIENT SUBSCRIBER?____ YES ____ NO EMPLOYER:______________

    SUBSCRIBER NAME: ______________ SS#: _____/____/______ DATE OF BIRTH: ____/___/____ PHONE #:____________

15. SECONDARY INSURANCE: ______________ IS PATIENT SUBSCRIBER?____ YES ____ NO EMPLOYER:______________

    SUBSCRIBER NAME: ______________ SS#: _____/____/______ DATE OF BIRTH: ____/___/____ PHONE #:____________

EMERGENCY CONTACT

17. LIST AN EMERGENCY CONTACT WITH A DIFFERENT TELEPHONE NUMBER:

    NAME: ______________ NUMBER: ( ) ____________ RELATIONSHIP: ____________

    ADDRESS:______________________ City:______________ State:________ Zip:__________

Revised: June 2017

Patient Label

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Health History / Cardiac Function Assessment

Ht:_______ **Wt:** _________ **Allergies:** ____

Primary Doctor: ____________________ **Last Visit:** ______________________________

Cardiologist: ______________________ **Last Visit:** ______________________________

Check all that apply:

Cardiac:

- ☐ Cardiovascular disease
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artery Disease (CAD) (blocked arteries)
- ☐ Open Heart Surgery
- ☐ Angina/Chest Pain
- ☐ Hypertension (high blood pressure)
- ☐ History of heart attack
- ☐ Atrial Fibrillation/Irregular Heartbeat
- ☐ Pacemaker
- ☐ Stents
- ☐ PTCA (percutaneous transluminal coronary angioplasty)
- ☐ Any type of cardiac procedure: ____________________

Respiratory:

- ☐ Emphysema/Chronic bronchitis/COPD
- ☐ Asthma requiring hospitalization
- ☐ Shortness of Breath
- ☐ Smoking over 10 years
- ☐ Sleep Apnea
- ☐ Tuberculosis (TB)

Hematology:

- ☐ Bleeding Disorder
- ☐ Anemia

GI/GU/Endocrine/Other:

- ☐ Kidney disease, Dialysis
- ☐ UTI - Burning, painful, frequent urination-Current
- ☐ Diabetes
- ☐ Cirrhosis/Hepatitis
- ☐ HIV
- ☐ Diagnosed Cancer
- ☐ Seizures
- ☐ Stroke History
- ☐ Latex Allergy
- ☐ Organ Transplant
- ☐ Prosthetic Implants-joint, cochlear, artificial heart valve, or any other implants

Medications:

- ☐ Taking Digoxin-Last dose date/time: ____________
- ☐ Taking Dilantin-Last dose date/time: ____________
- ☐ Taking diuretics (Lasix (Furosemide),HCTZ, water pill)
- ☐ Aspirin/Plavix/Coumadin
  Stop Date:______________

*******NURSE USE ONLY BELOW, DO NOT FILL OUT*******

Do you experience chest pain or shortness of breath during the following? Check all that apply.

1. _____ Dress self
   _____ Bathe
   _____ Walk slowly on 2 level blocks
   _____ Light housework (i.e. dusting, mowing, washing dishes)
   _____ Moderate housework (i.e. vacuuming, sweeping, carrying groceries).
   Poor (<4 METS)

2. _____Climb a flight of stairs or walk up hill
   _____ Sexual relations
   _____ Walk briskly
   _____Moderate recreational activities
   _____ Heavy housework (i.e. mow lawn with push mower, wash car, move heavy furniture)
   Moderate (4-7 METS)

3. _____ Climb stairs briskly or walk upstairs with 1-2 bags of groceries, climb 2 flights without stopping
   _____ Heavy outdoor work (i.e. saw wood, heavy lifting, gardening)
   _____ Strenuous sports (swimming, singles tennis, jog, basketball)
   Excellent (>7 METS)

HP Available: ☐ Yes ☐ No **LAB Available:** ☐ Yes ☐ No

Cardiac Clearance Available: ☐ Yes ☐ No **Previous EKG Available:** ☐ Yes ☐ No

Exercise Tolerance: ☐ Daily ☐ 2 X Week ☐ 3 X Week ☐ 4 X Week ☐ 5 X Week ☐ 6 X Week ☐ No Activity ☐ Other ________________________________

PATIENT LABEL

CONSENT FOR TREATMENT AND ACKNOWLEDGEMENTS

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** I consent to the procedures that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science an that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital.

2. **NURSING CARE** This hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

3. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS** I am advised that all physicians and surgeons furnishing healthcare services to me/the patient, including the radiologist, pathologist, anesthesiologist, etc., are independent contractors and are not employees or agents of the hospital. I am advised that I may receive a separate bill for these services. I understand that I/the patient am under the care and supervision of my/the patients attending physician., and it is the responsibility of hospital staff to carry out his/her instructions. I understand that it is the responsibility of my/the patients physician, surgeon or authorized healthcare provider to obtain my informed consent for surgical or complex medical treatment, special diagnostic or therapeutic procedures, investigational treatment or procedures, and/or other specialized hospital services.

4. **PERSONAL BELONGINGS** As a patient, I am encouraged to leave personal items at home. South Texas Surgical Hospital is not liable for the loss or damage of any money, jewelry, documents, or any other articles.

5. **FINANCIAL AGREEMENT** I agree to promptly pay all hospital bills in accordance with the regular rates and terms of the hospital, including its charity care and uninsured discount policies, if applicable. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services

ASSIGNMENT OF INSURANCE BENEFITS I assign and authorize direct payment to the hospital of all insurances benefits payable for this hospitalization or for these outpatient services. I agree that the insurance company's payment to the hospital pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this agreement.

6. **HEALTH PLAN OBLIGATION** This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. The hospital has no contract, express or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by the hospital if I belong to a plan that does not appear on the above mentioned list. All physicians and surgeons, including the radiologist, pathologists, emergency physician, anesthesiologist, and others will bill separately for their services. It is my responsibility to determine if physicians providing services to me contract with my health plan, if any.

Please Initial below:

______ Mission and Vision Statement

______ Conditions of Admission

______ Patient Rights with Regards to Complaints

______ Patient Rights and Responsibilities

______ Notice of Privacy Practice

______ Notice of Physician Ownership

DOES PHYSICIAN HAVE OWNERSHIP YES NO

Print Name: ______________________________

____
Signature of Patient or Authorized Representative

Witness: ______________________________

Date: ____________________ Time :____________

Patient Name:
Account Number:
Unit/MR Number:
Admit/Service Date:

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Smoking Status / Opt Out Form

SMOKING STATUS

CHECK ONE OF THE FOLLOWING QUESTIONS:

__________ Current someday smoker (does not smoke on a daily basis)

__________ Heavy Tobacco User (smokes 10 or more cigarettes per day)

__________ Light Tobacco User (smokes less than 10 cigarettes per day)

__________ Former smoker

__________ Never smoked

SUMMARY OF CARE / OPT OUT

South Texas Surgical Hospital will automatically send your Summary of Care (your hospital visit) electronically to your surgeon's office. Please mark below whether you wish to decline these services or not. **This will only be sent to surgeons that have the capability of accepting electronic files.**

__________ I wish to DECLINE sending Summary of Care electronically.

__________ I DO want my Summary of Care to be sent electronically.

PATIENT DIRECTORY / OPT OUT

South Texas Surgical Hospital has a Patient Directory for all Registered Inpatient Admissions.
Do you want to be restricted from the Patient Directory listing?
NOTE: The directory information only includes acknowledgement that the patient is at the facility, the patient's condition in general terms, and the location of the patient.

__________ Yes, restrict my visit from the Patient Directory and do not give out any information

__________ No, do not restrict my visit from the Patient Directory and it is ok to provide information

Date:______________ Time:______________ Patient / Responsible Party:__________________________

Version: December 2018

Patient Label

Your Right to Make Decisions About Medical Treatment

ADVANCE DIRECTIVES

This form explains your right to participate in health care decisions and how you can plan what should be done when you can't speak for yourself. A federal law requires us to give you this information. The law is intended to increase your control over medical treatment decisions.

Who decides about my treatment?
Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment that you don't want, even if the treatment might keep you alive longer.

How do I know what I want?
Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects." Your doctor must offer you information about problems that medical treatment is likely to cause you. Often, more than one treatment might help you and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

What if I become too sick to decide?
If you can't make treatment decisions, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time this works, but there are times when everyone doesn't agree about what to do. That's why it is helpful if you say in advance what you want to happen when you can't speak for yourself. There are several kinds of "advanced directives" that you can use to say what you want and who you want your doctors to listen to in this event.

Who can fill out this form?
You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

Who can I name to make medical treatment decisions when I'm unable to do so?
You can choose an adult relative or any other person you trust as your "agent" to speak for you when you're too sick to make your own decision.

How does this person know what I would want?
Once you choose someone, talk to that person about what you want. You can also write down in the "Power of Attorney for Health Care" when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent, and bring a copy with you when you go into a hospital or other treatment facility.

Sometimes, treatment decisions are hard to make and it truly helps your family and your doctors if they know what you want. The "Power of Attorney" also gives them legal protection when they follow your wishes.

What if I don't have anybody to make decisions for me?
You can still put in writing your wishes about treatment. Documents that do this are often called a "living will" because they take affect while you are still alive but have become unable to speak for yourself.

When you sign this form it tells your doctors that you don't want any treatment that would prolong your dying. All life sustaining treatment would be stopped if you were terminally ill and your death was expected soon, or if you were permanently unconscious. However, you would continue to receive treatment to keep you comfortable.

If you have a living will, the doctors must follow your wishes about limiting treatment or turn your care over to another doctor who will. You doctors are also legally protected when they follow your wishes.

If the living will does not suit you, you can fill out a non-statutory living will to state when you would or wouldn't want to be treated. There are many different living will forms available or you can just write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding about your treatment.

Can't I just tell somebody what I want?
You can talk with your doctors and ask them to write down what you've said in your medical chart. You can also talk with your family. People will be clearer about your treatment wishes if you write them down, and your wishes are more likely to be followed.

What if I change my mind?
You can change or revoke any of these documents at any time as long as you can communicate your wishes.

Will I still be treated if I don't fill out these forms?
Absolutely, you don't have to fill out any of these forms if you don't want to. You will still get medical treatment. We need you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that:

A Power of Attorney for Health Care lets you name someone to make treatment decisions for you when you are not able to speak for yourself, not just life-sustaining treatments. Besides appointing an agent, you can also use the form to say when you would and wouldn't want particular kinds of treatment.

If you don't have someone you want to appoint to make decisions when you're not able to, you can sign a living will to direct that life-prolonging treatments not be used in certain situations.

We also have information that tells you more about all the forms mentioned above and how to fill them out.

HOSPITAL POLICY STATEMENT

This health group supports a patient's right to participate in health care decision making. Through education and inquiry about advance directives, this Hospital encourages patients to communicate their health care preferences and values to others. We have formal policies to ensure that your wishes about treatment will be followed and we do not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an advance directive.

My signature acknowledges that I have received a copy of the Hospital's policy and my rights as outlined by the "Patient-Self Determination Act":

Indicate Status:
Do you have an Advance Directive? YES_____ NO_____
Would you like to be provided with the information on Advance Directives? YES_____ NO_____
Was patient provided with the copy of the Advance Directives information forms? YES_____ NO_____
Do you have a Living Will? YES_____ NO_____
Def: A document signed in advance in which decisions about health care treatment are set forth.
Do you have a Healthcare Proxy? YES_____ NO_____
Def: A court appointed agent to make health care decisions when you are not able to.
Are you an Organ Donor? YES_____ NO_____
Do you have a Power of Attorney? YES_____ NO_____
Def: Authorizes a person to make medical decisions.

_______I have not previously executed an Advanced Medical Directive and do not choose to execute one at this time.
_______I have not previously executed an Advanced Medical Directive. I choose to execute one at this time.
_______I have previously executed an Advanced Medical Directive and I have provided a copy.
_______I have previously executed an Advanced Medical Directive but did not bring it with me.
_______I chose to waive my current Advanced Medical Directive for this elective admission
_______I have summarized my Advanced Medical Directive as follow:

____
____

Its on file at:_________ Physician Office _________Home ______Other ______________________________

______________________________ ______________ ____________
Patient Signature Date Time