ONCOLOGY SAN ANTONIO
CANCER CARE NETWORK

Medical Oncology and Hematology

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Radiation Oncology

Kimberly Stewart, DO

Welcome to Oncology San Antonio. We pride ourselves on offering comprehensive, individualized medical care for patients with cancer and with blood disorders. We also are one of the few groups in San Antonio providing integrative oncology and a comprehensive breast program.

We welcome patients referred by their medical care provider or patients who refer themselves and it is an honor and privilege to have been selected to work with you.

We will create a plan of care that is individualized to your needs. We will go to great lengths to help you understand your condition and the available clinical research so that you can make an informed decision regarding your treatment plan.

Our goal is to make your experience as pleasant, relaxing, and informative as possible. Please complete the enclosed New Patient Packet, and return it to us during your first visit. You will also need the following documents to ensure your registration goes smoothly:

- Drivers license or official photo ID
- Current insurance card
- List of current medications, to include all prescribed medications, recreational medications, vitamins, and supplements
- List of all providers and specialists who provide care to you
- Completed new patient packet (enclosed)
- Previous medical records (if requested)

Please remember that your appointment time is valuable. If you are unable to make your appointment, please let us know at least 24 hours ahead of time so that we may schedule someone else that needs care.

Please plan to arrive 30 minutes prior to your appointment time to complete your registration and meet our front office team.

Should you have any questions, please do not hesitate to call 210.757.0301. We look forward to meeting you.

Rebecca Tepe
New Patient Coordinator
Oncology San Antonio Cancer Care Network

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Consent for EMR (Electronic Medical Record) Photography

Oncology San Antonio uses Electronic Medical Records **(EMR)** to maintain your health care information. The beneficial capabilities of the EMR allow us to use a digital photo to visually identify our patient while reviewing a chart. *Oncology San Antonio* will only use your picture for identification purposes. Your picture will not be included with any medical record releases or shown to anyone other than *Oncology San Antonio* staff for identification purposes. *Oncology San Antonio* is committed to maintaining the privacy and confidentiality of your health information, as defined in our Notice of Privacy Practices that complies with HIPPA.

You may, at any time, withdraw this consent with a written notice.

PLEASE CHECK ONE:

☐ YES. I agree to have my photo taken. I, _____, understand that by checking this box and signing this form, I am giving *Oncology San Antonio* permission to take a photo of me to use solely for identification purposes in the EMR. I understand the terms of the usage of my photo.

☐ NO. I wish not to have my photo taken and used for EMR identification purposes.

Signature of Patient: _____ **Date** ____ / ____ / _____

Consent for Email and/or Text Message Communication

Oncology San Antonio may be contacting you via email, text messaging and/or our patient portal to remind you of upcoming appointments, to obtain feedback, and to provide you with lab results.

With your signature below, you consent to receiving appointment reminders and other healthcare communications/information at that email address and/or mobile device from *Oncology San Antonio*.

_____ (Patient initials) I consent to receive text messages from *Oncology San Antonio* at my mobile phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders is
(_____) _____-_____

_____ (Patient initials) I consent to receive emails from *Oncology San Antonio* to receive communications about lab results, testimonial requests and general health reminders/information. The email that I authorize to receive email messages at is
_____@_____

Signature of Patient: _____ **Date** ____ / ____ / _____

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Patient's Bill of Rights

You have the right to considerate and respectful care.

You have the right to the most appropriate medical treatment available regardless of sex, race, religion, color, or national origin.

You have the right to obtain from your provider complete, current information concerning your diagnosis, treatment and possible outcome in understandable terms. When it is not medically advisable to give such information to you, the information will be made available to an appropriate person on your behalf.

You have the right to discuss with your provider any treatment, procedure, or operation planned for you so that you may understand the purpose, probable results, alternatives and risks involved before giving permission.

You have the right to refuse treatment to the extent permitted by law and government regulations, and to be informed of the consequences of your refusal.

You have the right to leave the office and facility, against your provider's advice, to the extent permitted by law and government regulations. If you leave the office or facility against your provider's advice, neither the facility, neither your provider, nor the United States Government will be responsible for any harm that this action might cause you or others.

You have the right to privacy concerning your medical care program in accordance with the law and regulations.

You have the right to a reasonable response to your request for service.

You have the right to obtain information as to any relationship of your facility to other health care and educational institutions in so far as your care is concerned. You have the right to obtain the name, position, and professional relationships of all individuals who are treating you.

You have the right to see another provider.

You have the right to be advised if the facility proposes to engage in or perform research associated with your care or treatment. You have the right to refuse to participate in such research projects.

You have the right to know which facility rules and regulations apply to your conduct as a patient.

If you have any questions or concerns regarding this form, please call 210.757.0301 or e-mail newpatient@oncologysa.com.

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Patient's Responsibilities

The Statement of Patient's Responsibilities, designed as a companion to the Patient's Bill of Rights, encourages patients to participate in their own health care and treatment. *Oncology San Antonio* believes that a mutual understanding of the Patient's Bill of Rights and Responsibilities will result in more effective delivery of health care services. To the extent possible, *Oncology San Antonio* requests that patients:

- Provide accurate and complete information about your past illnesses, hospitalizations, medications and other matters relating to your health, and answer any questions concerning these matters.
- Participate in your health care planning by talking openly and honestly about your concerns with your provider and other health care professionals.
- Understand your diagnosis and treatment to your satisfaction and ask questions if you do not understand your treatment plan.
- Cooperate with your provider and other health care professionals in carrying out your treatment plan.
- Participate and cooperate with our health care professionals in creating a discharge plan, which meets your medical and social needs.
- Inform *Oncology San Antonio* or any of its professionals of the existence of any advance directive (including health care proxy, power of attorney, DNR, living will) you may have created.
- Provide information relating to insurance and other sources of payment.
- Cooperate and abide by *Oncology San Antonio* rules, regulations and policies.
- We also ask that you be considerate of your fellow patients, respecting their need for privacy and a quiet environment, as we expect them to do for you as well.

If you have any questions or concerns regarding this form, please call 210.757.0301 or e-mail newpatient@oncologysa.com.

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Assignment of Benefits

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to *Oncology San Antonio,* as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by *Oncology San Antonio*, regardless of its managed care network participation status.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

I hereby authorize *Oncology San Antonio* to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to *Oncology San Antonio* any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from *Oncology San Antonio* or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to *Oncology San Antonio* any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from *Oncology San Antonio* (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to *Oncology San Antonio* all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by *Oncology San Antonio*, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims).

The assignee and/or designated representative (*Oncology San Antonio*) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator.

Oncology San Antonio and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature of Patient or Guardian: **Date:**

_____ ____ / ____ / _____

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Authorization to Release Medical Records

I, _____ (patient's full name), authorize *Oncology San Antonio* to release confidential health information about me to the individual(s) listed below:

1. Full Name: _____
Relationship to Patient: _____DOB: _____ / _____ / _____
Phone Number: (_____) _____-_____ Email (Optional): _____

2. Full Name: _____
Relationship to Patient: _____DOB: _____ / _____ / _____
Phone Number: (_____) _____-_____ Email (Optional): _____

3. Full Name: _____
Relationship to Patient: _____DOB: _____ / _____ / _____
Phone Number: (_____) _____-_____ Email (Optional): _____

4. Full Name: _____
Relationship to Patient: _____DOB: _____ / _____ / _____
Phone Number: (_____) _____-_____ Email (Optional): _____

I understand that the information released can include some or all of the following: a copy of my medical records, a summary or narrative of my protected health information, or a verbal conversation.
Note: While every attempt will be made to protect the privacy of your medical information, please note that release of your medical information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore is no longer protected by the Health Insurance Portability and Accountability Act (HIPPA) or other federal or state laws. This authorization will last in perpetuity unless you specify otherwise:

Special Notes or Requests by patient:

_____
_____
_____
_____

Full Legal Name of Patient (Please Print): **Patient Date of Birth:** **Patient SSN:**

_____ ____ / ____ / _____ _____-_____-_____

Signature of Patient or Guardian: **Date:**

_____ ____ / ____ / _____

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Medical Records Release Authorization

Patient name: _____Date of Birth: ____ / ____ / _____

Address: _____

Phone Number: (_____) _____-_____ Treatment dates from: ____ / ____ / _____ to ____ / ____ / _____

I authorize: (enter your current provider's information)

Provider name: _____

Address: _____

Phone Number: (_____) _____-_____

Fax Number: (_____) _____-_____

To release copies of my medical records to: (select provider)

☐ Basel Dabas, MD ☐ Zulfi Jaffar, MD ☐ Navneet Mittal, MD

☐ Jayasree Rao, MD ☐ Syed Raza, MD ☐ Kimberly Stewart, DO

☐ Angelia Berkowitz, DNP, APRN, FNP, AOCNP

☐ Rachel Balli, MSN, APRN, ACNP-BC ☐ Reylin Segura, MSN, APRN, FNP-BC

I understand that this information shall be in effect for one year following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the released copies.

I hereby release *Oncology San Antonio* from any and all liability which may arise as a result of my authorized release of records. Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Signature of Patient or Guardian: **Date:**

_____ ____ / ____ / _____

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Patient Demographic Form

Patient Data: _____

Title: (Check one) ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Nickname: _____ **Date of Birth:** _____ /_____ /_____**Sex:** ☐Male ☐Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Cell Phone: (_____) _____-_____ **Email:** _____

Social Security Number: _____-_____-_____ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Student ☐Retired ☐Other (check one)

Race: ☐Native American/American Indian ☐Asian ☐Black/African American ☐Pacific Islander ☐White

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Do not want to disclose

Referring Provider Info: _____

Referring Provider: _____ **Phone:** (_____) _____-_____

Primary Care Provider: _____ **Phone:** (_____) _____-_____

Surgeon: _____ **Phone:** (_____) _____-_____

Other Specialist: _____ **Phone:** (_____) _____-_____

_____

Pharmacy Info: _____

Pharmacy Name: _____ **Phone:** (_____) _____-_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact: _____

Name: _____ **Phone:** (_____) _____-_____

Relationship: _____

Name: _____ **Phone:** (_____) _____-_____

Relationship: _____

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Billing Information

Insurance Information: _____

Primary Insurance: _____
Policy Number: _____ **Group Number:** _____
Policy Holder: _____ **SSN:** ____-____-_____ **DOB:** ____ / _____ / _____
(*Name as it appears on the card)* (*Policy Holder)* (*Policy Holder)*
Employer Associated with Policy: _____

Secondary Insurance: _____
Policy Number: _____ **Group Number:** _____
Policy Holder: _____ **SSN:** ____-____-_____ **DOB:** ____ / _____ / _____
(*Name as it appears on the card)* (*Policy Holder)* (*Policy Holder)*
Employer Associated with Policy: _____

Additional Insurance: _____
Policy Number: _____ **Group Number:** _____
Policy Holder: _____ **SSN:** ____-____-_____ **DOB:** ____ / _____ / _____
(*Name as it appears on the card)* (*Policy Holder)* (*Policy Holder)*
Employer Associated with Policy: _____

_____

1. Are you currently staying in a Skilled Nursing Facility (SNF) or convalescent home?
Check One: ☐ YES ☐ NO If **YES:**

Facility Name: _____ **Phone:** (_____) _____-_____

2. Are you currently on hospice?
Check One: ☐ YES ☐ NO If **YES**:
What is your diagnosis? _____

3. Do you have a home health provider?
Check One: ☐ YES ☐ NO If **YES**:
Provider Name: _____ **Phone:** (_____) _____-_____

Full Legal Name of Patient (Please Print):
_____

Signature of Patient or Guardian: **Date:**
_____ ____ / ____ / _____

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History and Physical

Date: ____ / ____ / _____ Referring Provider: _____ Age: _____

Insurance: _____

Diagnosis:	**Date of diagnosis: ____ / ____ / _____**
History of present illness: **(to be filled out by staff)**	

Which provider(s) are involved with your care? **Please write in the name of each provider:**

Primary care/Internist: _____
Surgeon: _____
OB/GYN: _____
Other: _____

Have you had any scans, x-rays or other tests related to your diagnosis?

Test	**Yes**	**No**	**Performed where?**	**Date**
CT Scan				
MRI Scan				
Bone Scan				
Ultrasound				
Pet Scan				
BMD				
C-Scope				
Biopsy				
EGD				
Other				

Current Type of Treatment?

Test	**Yes**	**No**	**What hospital?**	**Date**
Surgery				
Radiation				
Drug TX/Chemo				
Hormone Therapy				

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History and Physical (continued)

Female History:

1. Do you have regular mammograms?
Check One: ☐ YES ☐ NO If **YES**:
Where? _____ Last Exam: ____ / ____ / _____
2. Do you have regular PAP tests?
Check One: ☐ YES ☐ NO If **YES**:
Where? _____ Last Exam: ____ / ____ / _____
3. Do you examine your own breasts?
Check One: ☐ YES ☐ NO _____ Last Exam: ____ / ____ / _____
4. Age that you started menstruation? _____ Age: _____
5. Have you had a hysterectomy?
Check One: ☐ YES ☐ NO If **YES**:
Were your ovaries removed? **Check One:** ☐ YES ☐ NO
6. Age at menopause? _____ Age: _____
7. Date of last menstrual period: _____ Date: ____ / ____ / _____
8. Have you ever used oral contraceptives?
Check One: ☐ YES ☐ NO If **YES**: How long? _____ Years
9. Do/did you use hormone replacement therapy?
Check One: ☐ YES ☐ NO If **YES**: How long? _____ Years
10. Total # of pregnancies: _____Total # of live births: _____ Total # of miscarriages: _____
11. Did you breastfeed?
Check One: ☐ YES ☐ NO If **YES**: How long? _____ Months

Male History:

1. Do you have regular prostate exams?
Check One: ☐ YES ☐ NO If **YES**:
Where? _____ Last Exam: ____ / ____ / _____
2. Do you have regular PSA tests?
Check One: ☐ YES ☐ NO If **YES**:
Where? _____ Last Exam: ____ / ____ / _____
3. Do you examine your own testicles?
Check One: ☐ YES ☐ NO _____ Last Exam: ____ / ____ / _____

ONCOLOGY SAN ANTONIO CANCER CARE NETWORK

History and Physical (continued)

Past Medical History:

Have you had any other cancers in the past?

Check One: ☐ YES ☐ NO If **YES**, list below:

Date Diagnosed	Treatment Received	Type of Cancer

Have you had radiation before?

Check One: ☐ YES ☐ NO If **YES**:

Where? _____ Date: ____ / ____ / _____

What type? _____

Have you had chemotherapy before?

Check One: ☐ YES ☐ NO If **YES**:

Where? _____ Date: ____ / ____ / _____

What type? _____

Do you have an Internal Electronic Device, i.e. defibrillator, pacemaker? ☐ YES ☐ NO

Past Medical History:

Have you ever been diagnosed with any of the following medical conditions?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Congestive heart failure
- ☐ Atrial fibrillation
- ☐ Heart attack
- ☐ Heart disease
- ☐ Thyroid Dysfunction
- ☐ COPD
- ☐ Asthma
- ☐ Stroke
- ☐ High cholesterol
- ☐ Stomach Ulcer
- ☐ GERD (Reflux)
- ☐ Pulmonary Embolism
- ☐ Bleeding Tendency
- ☐ DVT (blood clots)
- ☐ Glaucoma
- ☐ Kidney Problems
- ☐ Known Genetic Defects: _____

Other(s) _____

Past Surgical History:

Have you had any other procedures or operations?

- ☐ Open heart surgery
- ☐ Cardiac stent
- ☐ Thyroid
- ☐ Parathyroid
- ☐ Lung
- ☐ Hiatal hernia/reflux
- ☐ Ulcer
- ☐ Stomach resection
- ☐ Colon resection
- ☐ Gallbladder Removal
- ☐ Appendectomy
- ☐ Splenectomy
- ☐ Hernia
- ☐ Hysterectomy
- ☐ C-section
- ☐ Mastectomy
- ☐ Breast surgery
- ☐ Prostatectomy
- ☐ Removal of kidney
- ☐ Organ transplant (Type):_____
- ☐ Joint replacement (Type):_____

Other(s) _____

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History and Physical (continued)

Family History:

Do/did you have any family members who are/were diagnosed with cancer or a blood disease?

FAMILY MEMBER (please specify)	TYPE OF CANCER/BLOOD DISEASE	AGE AT DIAGNOSIS

Social History:

1. What is / was your occupation? _____ Retired ☐YES ☐NO
2. With whom do you live? _____ Live alone ☐YES ☐NO
3. Do you have children? ☐YES ☐NO Ages: _____
4. Have you ever smoked?
   Check One: ☐YES ☐NO If **YES**: #_____ packs per day for # _____ years
   If you used to smoke, when did you stop? _____ / _____ / _____
5. Do you drink alcohol?
   Check One: ☐YES ☐NO If **YES:** ☐ Beer ☐ Wine ☐ Spirits # of drinks per week: _____
   If you used to drink, when did you stop? _____ / _____ / _____
6. Have you ever used recreational drugs? (Marijuana, cocaine, etc.)
   Check One: ☐YES ☐NO If **YES:** Which drugs? _____
7. **Allergies:** (including medication, food, latex, peanuts, etc.)
   Check One: ☐YES ☐NO If **YES:** Describe allergy and reaction below**:**

ALLERGY TO	REACTION

List all medications that you are currently taking, including over the counter medications, supplements and vitamins. **(Skip to next question if providing separate medication list.)**

MEDICATION	DOSAGE	FREQUENCY

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Review of Systems

Please check all that apply:

GENERAL:
__ Chills
__ Sweats
__ Weight Gain
__ Weight Loss (last 6 months) –
How many pounds _____
__ Fatigue
__ Weakness
__ Fevers
__ Hot Flashes

HEENT (EYES, EARS, NOSE AND THROAT):
__ Blurred Vision
__ Double Vision
__ Loss of Hearing
__ Nose Bleeds
__ Hoarseness
__ Ringing in Ears
__ Bleeding Gums
__ Difficulty Swallowing

RESPIRATORY:
__ Cough
__ Shortness of breath:
On rest___ on exertion_____
__ Home oxygen: liters/min
_____
__ Sputum or phlegm
__ Blood in sputum or phlegm

CARDIOVASCULAR:
__ Chest Pain
__ Irregular Heart Beat
__ Palpitations
__ Ankle Swelling

ENDOCRINE/ METABOLIC:
__ Heat or cold intolerance
__ Poor control diabetes

HEMATOLOGICAL/ LYMPHATIC:
__ Easy bruising
__ Bleeding

SKIN:
__ Rash
__ Moles
__ Sores
__ Lumps
__ Healing incisions

PSYCHOSOCIAL/ BEHAVIORAL:
__ Depression
__ Anxiety
__ Sleep problems

BREAST:
__ Breast Lump
__ Breast Pain
__ Nipple Discharge

WOMEN ONLY:
__ Vaginal discharge
__ Abnormal vaginal bleeding
__ Painful intercourse

GASTROINTESTINAL:
__ Loss of Appetite
__ Vomiting
__ Diarrhea
__ Rectal Bleeding
__ Nausea
__ Abdominal Pain
__ Constipation
__ Black Stools

GENITOURINARY:
__ Urine Discoloration
__ Blood in urine
__ Burning urination
__ Painful urination
__ Frequent urination
__ Lack of bladder control

MUSCULOSKELETAL:
__ Pain Swelling

NEUROLOGICAL:
__ Headache
__ Seizure Memory Loss
__ Dizziness Tremors
__ Balance Problems
__ Weakness
Location: _____
__ Numbness
Location: _____
__ Tingling
Location: _____

MEN ONLY:
__ Erectile Dysfunction
__ Lump in Testicles
__ Penile Discharge
__ Breast Pain
__ Testicular Pain
__ Swelling
__ Lump

PAIN:
Location: _____
_____

How severe is your pain?

__ 0: Absent (No pain)
__ 1–2: Tolerable
(tolerate w/o medications)
__ 3–4: Bearable
(some activities restricted/ prevented, requires medication)
__ 5–6: Nearly intolerable
(sedentary, only able to watch TV, read, etc.)
__ 7–8: Intolerable
(can't read, watch TV, use phone, need to visit ER for pain killers)
__ 9–10: Devastating
(need hospitalization for pain control)

Review of Systems (continued)

Please complete all that apply:

GYNECOLOGIC:

1. Age of first period: _____
2. Age of menopause: _____
3. Number of pregnancies: _____
4. Number of births: _____
5. Use of oral contraceptives? Yes or No: _____
   a. How long?: _____
   b. When stopped?: _____
6. Use of hormones? Yes or No: _____
   a. How long?: _____
   b. When stopped?: _____

Any history of auto-immune disease?

Lupus: _____
Scleroderma: _____
Rheumatoid arthritis (active): _____
Connective tissue disorder: _____
Multiple sclerosis: _____
Type 1 Diabetes: _____
Thyroid issues: _____

Last dental visit: _____

Dentist name: _____
Dentist phone number: _____

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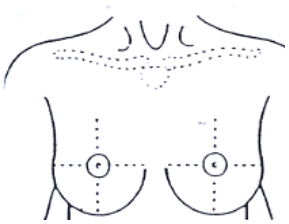
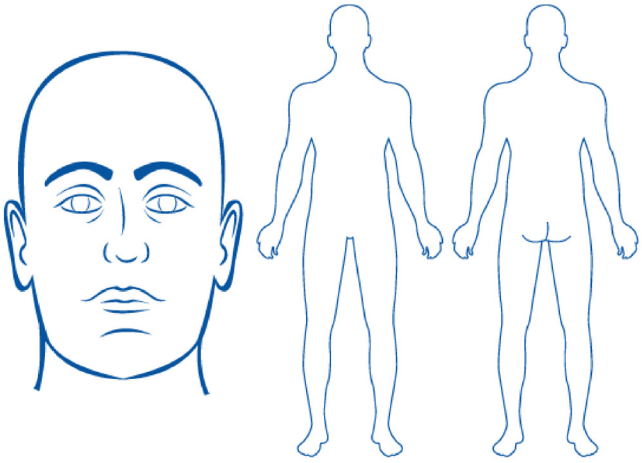
Physical Exam

This section will be completed by the nurse or provider.

Activity Level_____ Mode: Ambulatory_____ Wheel Chair_____ Stretcher_____
Ht._____ (ft. and in.) Wt._____ (lb.) B/P_____ P _____ R_____ T_____ 02 Stats_____%

GENERAL	
HEENT	
NECK	
LUNGS	
CARDIAC	
BREAST	
ABDOMEN	
EXTREMITIES	
MUSCULOSKELETAL	
GENITALS	
NEUROLOGICAL	
LYMPHATIC	



ASSESSMENT	PLAN

Signature of Provider:
_____

Date:
____ / ____ / _____