CAPE COD HOSPITAL
Wound Care Services

Patient Label

PATIENT HISTORY

GENERAL INFORMATION		DATE:	
▲ Name		▲ Primary Phone	
▲ Address		Secondary Phone	
▲ City		State	Zip
▲ E-mail	▲ Date of Birth	▲ Age	▲ Sex

SOCIAL HISTORY

Do you live alone: □ No □ Yes	Do you drive: □ No □ Yes	Employed: □ No □ Yes
What is the highest school grade you completed? □ 1-6 □ 7-9 □ 10 □ 11 □ 12 □ Some college □ College graduate		
Marital Status: □ Separated □ Divorced □ Married □ Single □ Widowed	Spouse Name:	
Do you smoke: □ No □ Yes If Yes, for how many years:	How many packs per day:	If quit, when:
Do you drink alcohol: □ No History □ Prior History □ Current History		Type:
Do you use recreational drugs: □ No □ Yes If Yes, amount:		Type:
Caffeine Use: □ No □ Yes If Yes, for how many years:	How many cups per day:	
Financial Concerns: □ Yes □ No	Food/Clothing/Shelter Needs: □ Yes □ No	
Support System Intact: □ Yes □ No	Transportation Concerns: □ Yes □ No	
How will you travel to center: ☐ Car ☐ Ambulance ☐ Ambulette ☐ Public ☐ Other		

EMERGENCY CONTACT INFORMATION

Name	Primary Phone
Relationship	Secondary Phone

▲ *What provider referred you to the Wound Care Center®?*

Name	Specialty	Phone	
Address	City	State	Zip

▲ *Who is your primary provider?*

Name	Specialty	Phone	
Address	City	State	Zip

▲ *If your provider did not refer you, how did you hear about our Wound Care Center®?*

☐ Self-referral ☐ Extended Care Facility (SNF, LTAC, Nursing Home) ☐ Advertising
☐ Former patient ☐ Home Health ☐ Friend/Family
☐ Recently discharged from this hospital ☐ Recently discharged from another hospital

Please provide contact information (if applicable):

Home Health Agency:	Phone
Nursing Home/Skilled Nursing Facility:	Phone
Pharmacy:	Phone

Do you have any of the following?

Advance Directive:	Living Will:	Medical Power of Attorney:	Do Not Resuscitate:
□ Yes* □ No	□ Yes* □ No	□ Yes* □ No	□ Yes* □ No

*Copy required for chart. Requested by: _____ Date: _____ Time: _____
□ Copy provided. Signature: _____ Date: _____ Time: _____

WOUND HISTORY

Name of Person Completing Form: _____ Relationship to Patient: _____
Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____

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PATIENT HISTORY

Wound location:		
When did you first notice the wound?	Has it ever healed and then re-opened? □ Yes □ No	
How did your wound start? □Bite □ Blister □ Bruise □ Bump □ Chemical Burn □ Footwear □ Frostbite □ Gradually Appeared □ Not Known □ Other Lesion □ Pimple □ Pressure □ Radiation Burn □ Surgical □ Thermal Burn □ Trauma		
How have you been treating your wound until now?		
Have you had any lab work done in the past month? ☐ No ☐ Yes	If Yes, Who Ordered?	
Have you ever had bacteria that resisted antibiotics)? ☐ No ☐ Yes		If Yes, Date:
Have you ever had a bone infection? ☐ No ☐ Yes		If Yes, Date:
Have you had any tests for blood flow in your legs? ☐ No ☐ Yes		If Yes, Date:
If Yes, Where was it done:	Who ordered?	
Have you had any other problems with your wound? ☐ Infection ☐ Swelling ☐ Other		

PATIENT'S MEDICAL HISTORY (Please check Yes or No for each item)

	Yes	No		Yes	No
Cataracts (Cloudy vision)			Cirrhosis (Liver problems)		
Glaucoma (Eye disease)			Colitis/Crohn's (Bowel problems)		
Chronic Sinus problems/congestion			Hepatitis (Type:)		
Middle ear problems			Thyroid Disease		
Ear Surgery			Type I Diabetes		
Anemia (Tired, or low iron)			Type II Diabetes		
Hemophilia (Bleeding disorder)			End Stage Renal Disease (Kidney disease)		
Human Immunodeficiency Virus (HIV)			On Dialysis (Type:_____)		
Lymphedema (Swelling in legs or arms)			Lupus (Problem with your immune system)		
Sickle Cell Disease			Raynaud's Syndrome (Problem with blood flow to your fingers or toes)		
Aspiration			Scleroderma (Skin disorder)		
Asthma (Breathing problem)			Rheumatoid Arthritis (Swelling of joints)		
Chronic Obstructive Pulmonary Disease (COPD)			History of Burn		
Pneumothorax (Collapsed lung)			Gout (Pain in big toes)		
Sleep Apnea (Stop breathing when sleeping)			Osteoarthritis (Pain in bones or joints)		
Tuberculosis (infection in the lungs)			Dementia (Memory loss that gets worse over time)		
Angina (Chest pain)			Neuropathy (Numbness in hands or feet)		
Arrhythmia (Skipped heartbeat)			Paraplegia (Can't move arms or legs)		
Atrial Fibrillation (Rapid heart rate)			Quadriplegia (Can't move arms and legs)		
Congestive Heart Failure			Received Chemotherapy		
Coronary Artery Disease (Heart disease)					
Deep Vein Thrombosis (Blood clot in leg)			Surgery		
Hypertension (High blood pressure)			Anorexia/bulimia		
Hypotension (Low blood pressure)			Confinement Anxiety (Fear about being in a closed space)		
Myocardial Infarction (Heart attack)					
Peripheral Arterial Disease (Problem with blood flow in your legs)			Peripheral Venous Disease (Problem with blood vessels in your legs)		
Vasculitis (Inflammation of your blood vessels)			Phlebitis (Inflammation of the veins in your legs)		

Name of Person Completing Form:_____ Relationship to Patient:_____
Signature: _____Date: _____ Time: _____

Reviewed By: _____Date:_____Time: _____
Reviewed By: _____Date:_____Time:_____

Patient Label

PATIENT HISTORY

FAMILY MEDICAL HISTORY (*Please indicate with a checkmark if any of your family members have/had this condition)*

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Tuberculosis					

HOSPITALIZATION/SURGERY HISTORY (*Please list all)*

NAME OF HOSPITAL	REASON YOU WERE IN THE HOSPITAL	DATE

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center® for your first visit.

For Healthcare Provider Use Only

NOTES:

Name of Person Completing Form:_____ Relationship to Patient:_____
Signature: _____Date: _____ Time: _____

Reviewed By: _____Date:_____Time: _____
Reviewed By: _____Date:_____Time:_____

Patient Label

PATIENT CONSENT TO WOUND CARE TREATMENT

(Note: This form is to be signed by all Wound Care Center Patients. If Patient is going to receive Hyperbaric Oxygen Therapy, then Patient must also execute the Patient Consent to Hyperbaric Oxygen Therapy Consent Form).

PATIENT NAME ("Patient"): _____ DATE OF BIRTH: _____
HOSPITAL ("Hospital"): _____

You have the right, as a patient, to be informed about your condition and any recommended medical procedures so you can make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. By signing this Consent, Patient voluntary consents to receive wound care treatment provided by Hospital and its contractor Healogics, Inc. ("Healogics") and their respective employees, agents, representatives and affiliated companies (sometimes collectively referred to as a Wound Care Center ("WCC")). Patient understands that this Consent will remain in effect from the date this Consent is signed until the patient is discharged from receiving care, treatment, and services at the WCC. A new consent will be obtained if Patient is discharged from the WCC and returns for care, treatment, or services. Patient understands Patient has a right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance. When a Patient is unable to consent to treatment (such as because of incapacity or age), the term Patient below means the legal representative authorized to act on behalf of the person receiving treatment under this Consent.

1. General Description of Patient's Medical Condition and Wound Care Treatment: Patient acknowledges that Provider has explained Patient's general medical condition to Patient. Patient further acknowledges that Provider has informed Patient that Patient's treatment in the WCC may include, but is not be limited to, debridements, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as blood, urine and other studies), x-rays, hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a provider. Patient acknowledges that Provider has given Patient the opportunity to ask questions about treatment, Patient has asked any questions Patient has about treatment, and Provider has answered all of Patient's questions regarding treatment that may be provided to Patient in the WCC.

2. Benefits of Wound Care Treatment: Patient acknowledges that Provider has explained the potential benefits of treatment in the WCC, including enhanced wound healing and reduced risks of amputation and infection.

3. Risks and Side Effects of Wound Care Treatment: Patient acknowledges that Provider has explained that treatment in the WCC may cause side effects and involve risks including, but not limited to, infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels, possible damage to surrounding tissues, possible damage to organs, possible damage to nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin preparation solutions, removal of healthy tissue, and prolonged healing or failure to heal.

4. Likelihood of achieving goals: Patient acknowledges that Provider has explained that, by following Provider's plan of care, Patient is more likely to have a favorable outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes. Patient specifically acknowledges and agrees that no representation made to Patient by Provider, Hospital or Healogics constitutes a Warranty or Guarantee that Patient will experience any result or cure.

5. Refusal of WCC Treatment: Patient acknowledges that Patient has been made aware that Patient may refuse any or all treatment in the WCC. Patient acknowledges that, if Patient refuses treatment in the WCC, Patient will not receive certain advanced wound care therapies that might benefit the patient.

6. Alternative to WCC Treatment: Patient acknowledges that Patient has been made aware that, in lieu of treatment in the WCC, Patients may continue a course of treatment with Patient's personal provider or may decide not to seek further treatment. Patient acknowledges that Provider has explained that, if Patient chooses to continue a course of treatment with Patient's personal provider or forego any treatment, Patient may not experience the risks and/or side effects associated with treatment in the WCC. Patient may experience prolonged healing or failure to heal, infection, and possible amputation if Patient's wound is on one of Patient's limbs.

Patient Initials: _____

Patient Label

PATIENT CONSENT TO WOUND CARE TREATMENT

7. General Description of Wound Debridements: Patient acknowledges that Provider has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of treatment in the WCC, multiple wound debridements may be necessary and will be performed by an authorized practitioner.

8. Risks and Side Effects of Wound Debridement: Patient acknowledges that Provider has explained the risks or complications of wound debridement include, but are not limited to, scarring, damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin preparation solutions, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient specifically acknowledges that Provider has explained that bleeding after debridement may cause a patient who is already in poor health to get worse more rapidly than if the debridement had not been performed. Patient specifically acknowledges that Provider has explained that drainage of an abscess or debridement of necrotic (dead) tissue may cause bacteria and bacterial toxins to be released into the bloodstream and cause severe sepsis or septic shock. Patient specifically acknowledges that Provider has explained that debridement will make Patient's wound larger due to the removal of dead tissue from the edges of the wound.

9. Patient Identification and Wound Images: Patient understands and consents to having images (digital, film, etc.), taken of Patient and Patient's wounds with their surrounding anatomical features. These images are taken for treatment purposes, including for the ability to monitor the progress of wound treatment and to provide for continuity of care. The images may be considered protected health information (PHI) and will be handled, maintained, and retained in a confidential, secure, and protected manner in accordance with applicable laws, regulations, and Hospital privacy and retention policies. Patient understands that the Hospital will retain ownership rights to these images and Patient expressly waives any and all rights to royalties or other compensation for these images. Patient understands that Patient may view or obtain copies of the images in accordance with applicable laws, regulations, and policies.

10. Financial Responsibility: Patient understands that, Patient is responsible for any costs associated with Patient's treatment that are not covered by insurance.

Patient Initials: _____

Patient Label

PATIENT CONSENT TO WOUND CARE TREATMENT

Patient hereby acknowledges that Patient has read this document or had it read to him or her, understands and agrees to the information in this document, and has had the opportunity to ask questions and receive answers to questions about this document and the information in this document.
By signing below, Patient consents to the care, treatment, and services explained to Patient by Provider and described in this document and consents to the creation of images of Patient's wounds…

_____ _____ _____ _____
Patient Signature or parent (if minor) Relationship Date Time

_____ _____ _____
Witness Signature Date Time

Interpreted by: _____(if applicable)

In the event above not signed by patient, the undersigned acknowledges that they have the legal right to sign the document.

_____ _____ _____
Legal Guardian or Legal Representative Date Time

Printed Name: _____Relationship: _____

The undersigned Provider has explained to Patient (or Patient's legal representative), the nature of Patient's proposed treatment or procedure(s), reasonable alternatives to such treatment or procedure(s), likelihood of achieving Patient's goals with regard to such treatment or procedure(s), and the potential benefits, risk, side effects, complications and consequences relating to such proposed treatment or procedure(s).

_____ _____ _____
Signature of Provider Date Time

Patient Initials: _____