JOHNS HOPKINS
MEDICINE

New Patient Appointment Questionnaire
Institute of Genetic Medicine, Johns Hopkins

Dear Patient/Parent,
Thank you for your interest in having a clinic appointment in the Institute of Genetic Medicine at Johns Hopkins. Because of the expanding field of genetics and growing interest/knowledge of medical professionals and the general public, we have an increasing demand for appointments.

IMPORTANT: If you are pregnant, if your child is losing developmental milestones, or if your child is under 6 months of age and is unable to gain weight/grow properly (has failure to thrive), please DO NOT complete this packet call your primary care physician to contact our office directly on your behalf for an urgent appointment: 410-955-0317.

In order for us to continue to provide excellent care for our patients, we ask that you fill out the attached questionnaire regarding the patient who you are making this appointment for. Once completed, please return the questionnaire back by fax, mail or email (details below). If you have not already, please also fax pertinent medical records to the address below:

Fax: 410-614-9246, Attention to: New Appointment Records, General Clinic

Email: geneticsappt@jhmi.edu Please use subject line: New Appointment Records. **You must also complete and return the Johns Hopkins HIPPA Email Release to initiate email communication, provided from the office with this questionnaire.*

Mail: Institute of Genetic Medicine
Johns Hopkins University
ATTN: General Clinic Intake
600 N. Wolfe St, Blalock 1008
Baltimore, MD 21287

Once we receive your questionnaire and any additional records, a genetic counselor will review your information and determine the appropriate physician to see the patient and determine if there are any needed ancillary appointments to be scheduled before or on the day of the appointment. Appointments will be scheduled in the order questionnaires are received. We will do our best to have the patient scheduled as soon as possible, however please be patient as we have a high volume of appointment requests.

Feel free to contact us with any questions or concerns at 410-955-0317.

Sincerely,

Institute of Genetic Medicine
Johns Hopkins University

Revised: September 29, 2015

This questionnaire is to be completed if you/your child was referred to the GENERAL GENETICS CLINIC. If you/he/she was supposed to be referred to a specialty clinic, please contact our office at 410-955-0317 to be sent another questionnaire. **Please print clearly.**

Patient's Name: _____

Patient's Date of birth: _____/_____/_____

Name of referring doctor (indicate 'self-referral' if no referring doctor):
Doctor Name: _____ **Phone:** _____

Reason(s) for appointment: _____

Has the patient ever seen a genetics specialist before? Yes / No (circle one)
If **YES**, please list the name and the location of this specialist(s):
_____
If YES, please list any genetic testing/evaluations that have been performed (Ex. single gene test, karyotype, microarray), and mail or fax copies of the results:
_____

It is helpful for us to better understand the patient's <u>DEVELOPMENTAL HISTORY</u>:

1. What is the patient's current age? _____ months / years (circle one)

2. What do you think is the patient's approximate 'developmental age' (Ex. they 'behave like a 12 month old')? _____ months / years (circle one)

3. Has the patient ever had a formal development assessment? Yes / No (circle one)
   If **YES***, who performed the assessment?
   - ☐ Developmental Pediatrician_____
   - ☐ Pediatrician _____
   - ☐ School_____
   - ☐ Other _____

   **Please include a copy of any formal assessments with this questionnaire.*

4. Is your child in any therapies? Yes / No (circle one)
   If YES, what type(s)?
   - ☐ Physical therapy (PT)
   - ☐ Occupational therapy (OT)
   - ☐ Speech/Language therapy (ST)
   - ☐ ABA or other Behavioral therapy
   - ☐ Other _____

5. Has the patient received any developmental diagnoses already? Yes / No (circle one)
   If YES, which one(s)?
   - ☐ Autism
   - ☐ Pervasive developmental disorder (PDD, PDD-NOS)
   - ☐ ADD/ADHD

☐ Oppositional defiance disorder (ODD)
☐ Other _____

It is helpful for us to better understand the patient's <u>MEDICAL PROBLEMS</u>:

1. Does the patient have any of the following health problems? If so, please provide details:
   - ☐ Heart defect ('hole in heart')? _____
   - ☐ Kidney (renal) abnormalities? _____
   - ☐ Seizures? _____
   - ☐ Cleft lip and/or cleft palate? _____
   - ☐ Hearing loss? _____
   - ☐ Vision problems/eye abnormalities? _____
   - ☐ Any other birth defect requiring surgery? _____
   - ☐ Tall or short stature? (circle one)_____
   - ☐ Large or small head? (circle one) _____
   - ☐ Birthmarks (please indicate how many and color)? _____
   - ☐ Other physical differences/medical problems?_____

     _____

2. Has the patient ever had any imaging (Ex. MRI, CT, X-rays, bone age, echocardiogram) or lab tests that were abnormal? Yes / No (circle one)

   If **YES***, please provide details:

   - _____
   - _____
   - _____
   - _____
   - _____

   **Please include a copy of any abnormal imaging reports and/or lab test results with this questionnaire.*

3. Please list ALL doctors/specialists who this patient sees and the reason(s):
   - _____
   - _____
   - _____
   - _____
   - _____

4. Is there any other important information about the patient we should know prior to scheduling his/her appointment? Please list here:

It is helpful for us to better understand the patient's <u>FAMILY HISTORY</u>:

1. Is there anyone else in the family with major health or developmental concerns? If so, please provide information about these concerns and how each person is related to the patient:
   - _____
   - _____
   - _____

Johns Hopkins Medicine

- ☐ Johns Hopkins Hospital
- ☐ Johns Hopkins Bayview Medical Center
- ☐ Howard County General Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS*

For this authorization, "My Health Information" is:

___ Complete Record (all)	___ Abstract Record (discharge summary, operative notes and test results)	
___ Discharge Summary	___ Operative Report	___ Pathology Report
___ Outpatient Record	___ Drug & Alcohol Treatment Record	___ Immunization Record
___ Mental Health Records	___ Admission History & Physical	___ Emergency Room Record
___ Diagnostic Test/Results (lab, x-rays and other test results)		

Other: _____

For the date(s) of service starting: _____
(insert date(s) of service requested)

I authorize _____
(insert entity)

to disclose My Health Information to Johns Hopkins Genetics for
(insert name of person or entity)

Medical Management.
(insert purpose)

My Health Information should be faxed to 410-614-9246 **OR** sent to:

JHH IGM/Attn:
(insert contact name at entity, if applicable)

600 N. Wolfe St., Bk Lock 1008
(insert street address)

Baltimore, MD 21287
(insert city, state and zip code)

I understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

This authorization is valid for one year from date signed, unless I revoke this authorization. Johns Hopkins may contact me to extend this authorization, but I do not have to do so.

Johns Hopkins' medical and administrative staff are pledged to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal law. Johns Hopkins has procedures in place to support this policy. These procedures make it very unlikely that my health information will be improperly redisclosed. However, if this happens, my health information may no longer be covered by these privacy protections.

I am not required to sign this authorization. Johns Hopkins does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. However, if I do not sign this authorization, Johns Hopkins will not disclose my health information as requested. I will receive a copy of this authorization upon signature.

I may revoke this authorization at any time in writing by following the guidelines on the back of this form.

Patient Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Address: _____
(street address)

_____
(city) (state) (zip code)

Phone: _____
(area code) (home phone number)

Medical Record #: _____

SSN: _____ **Birth Date:** _____

For healthcare agent/guardian/surrogate/parent/Personal Representative of the deceased,
(circle one of the above)

I, _____**, represent that I am the representative for the patient as circled above.**
(insert your name)

Representative's Signature: _____

Address: _____ **Phone:** _____

If you are the healthcare agent or guardian or court appointed Personal Representative of the deceased, please attach proof of your authority to act on behalf of the patient.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

*** Not to be used in connection with health information from substance abuse treatment programs.**

Request for E-mail Communications Between Johns Hopkins Provider and Patient

Patients Are Advised to Think Carefully before Choosing to Send or Receive Personal Information by E-Mail

E-mail is a common and useful form of communication; it is used by almost everyone. However, there are some concerns with using unencrypted e-mail as a means to communicate health information and other personal information.

Before choosing to communicate with your provider by e-mail, you should understand that unencrypted e-mail is not secure—that means that it could be intercepted and seen by others. In addition, there are other risks associated with unencrypted e-mail, such as:

- misaddressed/misdirected messages
- e-mail accounts that are shared with others
- messages forwarded on to others
- messages stored on portable devices having no security

A balance must be struck between making information available and the risk of data loss, misdirection or theft. Judgment should be exercised in all instances when deciding whether to send or receive personal information by unencrypted e-mail. If the decision is to send and receive personal information by e-mail, common sense steps should be taken:

- verifying the correct e-mail address each time used
- if the address is pulled from a directory, double checking to make sure the correct person's address is inserted, particularly with fairly common names
- sending only the minimum amount of information necessary to achieve the purposes of the communication
- considering carefully using alternative forms of communication if you are going to discuss sensitive information
- if you do not wish to have your personal information sent to you by e-mail, contact the sender immediately

If you choose to communicate with more than one provider at Johns Hopkins, you must complete a separate Request for E-Mail Communications form for each provider. Similarly, if you wish to terminate communication by E-Mail, you must contact each provider with whom you have previously submitted a Request form.

Johns Hopkins reserves the right to deny a request for e-mail communication under circumstances permitted by law.

If you still want to arrange to communicate with one or more Johns Hopkins' providers by unencrypted E-Mail, please proceed to page 2.

If this request is being signed in a face to face meeting with your provider, complete Parts 1 and 2 and return the request to the provider or provider's representative.

If this request is being submitted remotely, then Parts 1, 2 and 3 must be completed and the completed form submitted to the provider.

In either case, the provider or provider's representative will complete Part 4 and give a copy of the form to you.

PART 1

Date: _____

Patient's Name (print name): _____

Patient's email address (print): _____

Provider's Name (print name):_____

Part 2

The undersigned, being the patient named above, acknowledges that I have received, reviewed and understand the advice to think carefully about using E-mail to communicate personal information. In exchange for the convenience of this form of communication, I am willing to accept the associated potential risks. I represent that I am the patient named above.

Patient's Signature: _____

Part 3

In order to verify the identity of the person communicating remotely, the patient is required to provide some additional personal identifying information, as follows:

Medical Record Number: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Last 4 digits of Social Security Number: _____

Mother's Maiden Name: _____

Part 4

Provider's email address (print): _____

Provider's Signature: _____