PLAYING IT SAFE Cardiac Screening Intake Form

Patient Information:

First Name: MI Last Name:

Date of Birth Month Day Year

Address:

City State Zip

Telephone: Second Phone

Parent/Guardian Name:

Primary Physician: Physician's Address:

Physician's Telephone: Physician's Fax Number:

Patient History:

YES ❑ NO ❑ 1. Has your child fainted or passed out DURING exercise, emotion, or startle?

YES ❑ NO ❑ 2. Has your child fainted or passed out AFTER exercise?

YES ❑ NO ❑ 3. Has your child had extreme fatigue associated with exercise different than other children?

YES ❑ NO ❑ 4. Has your child ever had unusual/extreme shortness of breath during exercise?
If Yes does your child have Asthma? Yes ❑ No ❑

YES ❑ NO ❑ 5. Has your child ever had discomfort, pain, or pressure in his/her chest during exercise or complained of his/her heart "racing" or skipping beats?

YES ❑ NO ❑ 6. Has a doctor ever told you that your child has high blood pressure, high cholesterol, heart murmur, or a heart infection?
(If "yes," check all that apply) ❑ high blood pressure ❑ high cholesterol ❑ heart murmur ❑ heart infection

YES ❑ NO ❑ 7. Has a doctor ever ordered a test for your child's heart?

YES ❑ NO ❑ 8. Has any treatment been necessary?

YES ❑ NO ❑ 9. Has your child ever had any type of heart surgery? If yes please specify procedure done and at what age this occured
_____

YES ❑ NO ❑ 10. Has your child ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma?

Family History Questions:

YES ❑ NO ❑ 1. Have any family members experienced sudden, unexpected death before age 50? (Including sudden infant death syndrome (SIDS), car accident, drowning, and other causes?)

YES ❑ NO ❑ 2. Have any family members died suddenly of "heart problems" before age 50? If yes, with which degree of relative did this occur ❑ Parent ❑ Grandparent ❑ Other - Please specify _____

YES ❑ NO ❑ 3. Have any family members experienced unexplained fainting or seizures?

4. Are there relatives with conditions such as:

YES ❑ NO ❑ Hypertrophic Cardiomyopathy (HCM)

YES ❑ NO ❑ Dilated Cardiomyopathy (DCM)

YES ❑ NO ❑ Aortic rupture of Marfan Syndrome

YES ❑ NO ❑ Coronary artery atherosclerotic disease (heart attack at age 50 or younger)

YES ❑ NO ❑ Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)

YES ❑ NO ❑ Long QT Syndrome (LQTS) or Short QT Syndrome

YES ❑ NO ❑ Brugada Syndrome (Heart rhythm disorder characterized by an abnormal heartbeat called "Brugada")

YES ❑ NO ❑ Catecholaminergic Polymorphic **Ventricular Tachycardia** (CPVT)

YES ❑ NO ❑ Primary pulmonary hypertension (lung hypertension)

YES ❑ NO ❑ Pacemaker or implanted cardiac defibrillator. If yes, with which degree of relative did this occur
❑ Parent ❑ Grandparent ❑ Other - Please specify _____

YES ❑ NO ❑ Congenital deafness (deaf at birth)

*Family and patient history are an important part of screening for cardiac conditions. If you choose not to complete this form, or are otherwise unable to provide complete or accurate answers regarding family or the child's own history, the cardiac screening of your child may not be as thorough as possible. Barnabas Health Outpatient Centers may or may not collect this form at the same time as performing tests today on your child. Even if this form is collected today, Barnabas Health Outpatient Centers shall not be responsible for reviewing the information that you choose to include on this form, but if you do complete this form and provide it to Barnabas Health Outpatients Center today, then the form, and the information you provide, may be shared by Barnabas Health with your child's pediatrician and a referring cardiologist if your child is found to have a cardiac condition which requires further evaluation. Whether or not you provide a completed form today to Barnabas Health, we encourage you to fill out this form as correctly and completely as possible, and discuss the contents of this form with your child's pediatrician, as an additional cardiac screening tool.

Barnabas Health

2863 – 04/14

INFORMED CONSENT
FOR PRE-PARTICIPATION CARDIOVASCULAR SCREENING

_____

Patient Name

REQUEST AND PERMISSION FOR CARDIOVASCULAR SCREENING

1. **Permission.** I hereby request and authorize Saint Barnabas Medical Center and its employees, medical staff and agents (collectively, "SBMC") to perform cardiovascular screening (the "Screening") on me (my child). I understand that such Screening will involve the taking of an abbreviated medical history focused on cardiac health and performance of an EKG. On the basis of this Screening, I (my child) may be referred to specialists for additional testing. I also understand that there are other higher level screening tests that could be performed, such as echocardiograms and exercise testing, but will not be performed as part of the Screening, and I should discuss the need for higher level screening with my (my child's) physician. I understand that in no event will I (my child) be treated for any condition, given a definitive diagnosis or given recommendations regarding continued participation in sports or athletic events solely on the basis of the Screening.

2. **Objectives of the Screening**. In a very limited number of occasions, individuals who participate in sports and athletic events have a specific risk factor(s) that make such individuals predisposed to a cardiac arrest and/or sudden death during, or immediately following such athletic activities (the "Specific Risk Factor"). I understand that the objective of the Screening is to evaluate whether I (my child) may require further cardiovascular testing or intervention to identify a Specific Risk Factor. I understand that the Screening is neither a comprehensive exam, nor a medical clearance for participation in such sports and athletic events, and I (my child) will not be evaluated for other conditions that are unrelated to my (my child's) cardiac function. I understand that, regardless if I (my child) participate(s) in the Screening, I should consult with my (my child's) physicians if I (my child) intend(s) to participate in any sports or athletic activities. Furthermore, if I have any concerns regarding my (my child's) physical condition, I (my child) should seek additional medical evaluation and treatment.

3. **Inherent Risks**. I further understand that there are inherent risks in participating in sports and other athletic events and participation in the Screening will not reduce the inherent risks associated with sports or athletic events. Furthermore, the Screening does not reduce the risks associated with having a Specific Risk Factor, and therefore, even if the Screening leads to a referral, cardiac arrest or death could occur, whether or not participating in sports or other athletic events.

4. **Other Causes**. There are other possible causes of cardiac arrest and sudden death in athletes unrelated to the Specific Risk Factors, including, without limitation, use of illicit drugs, eating disorders and accidents. I understand that the Screening is not designed to identify all of the other causes of cardiac arrest or sudden death, and therefore, if any of these other causes occur or are present, I (my child) am (is) at risk for physical harm or injury, including sudden death, even though the Screening does not identify such issues. I understand that I should discuss these other causes with my (my child's) physician who can provide advice regarding evaluation or treatment, as necessary.

5. **Explanation of Screening.** The procedure(s) involved in the Screening have been explained to me and I have been provided with the necessary information for me to evaluate the risks and benefits of the proposed Screening. I have also received information regarding: (a) the nature and purpose of the Screening; (b) alternatives to the Screening, as well as the relevant risks and benefits of such alternative procedures; (c) clinical outcome if I do not elect to have the Screening; (d) the potential benefits and possible risks, side effects and complications associated with the Screening; and (e) the likelihood of achieving the goals of Screening. I have been given an opportunity to ask questions and all my questions have been answered satisfactorily.

6. **No Guarantees.** I am aware that there are certain risks and hazards connected with any treatment or screening that may result in complications or other consequences. I also know that no one can predict with certainty the results of medical treatment or screening because the practice of medicine is not an exact science. I acknowledge that no guarantees or assurances have been made to me concerning my (my child's) Screening. I understand that this Screening is only able to identify a certain limited number of Specific Risk Factors associated with cardiac conditions and that there are other symptoms and Specific Risk Factors that cannot be identified by the Screening. Therefore, regardless of the results of the Screening, I am not guaranteed that I (my child) do (does) not have a Specific Risk Factor. I am aware that unforeseen Specific Risk Factors may develop after the Screening, particularly in adolescents, and if I (my child) am (is) in high school, I (my child) should have the Screening repeated at least every two years (and every 3-4 years for college-age individuals) or earlier if symptoms develop and/or manifest. I understand that during the course of the Screening, additional conditions may be identified (although there is no guarantee that each and every condition that is present will be identified).

7. **Understanding of this Form.** I confirm that I have read and understand the above and all the blank spaces have been completed prior to my signing. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

Patient/Relative
or Guardian:_____ _____ _____
Signature Print Name Date

Relationship If Signed By Other Than Patient:_____

Witness/Interpreter:_____ _____ _____
Signature Print Name Date

Barnabas Health

MATTHEW J. MORAHAN HEALTH ASSESSMENT CENTER FOR ATHLETES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____DOB_____

ADDRESS:_____

TELEPHONE: _____

I hereby authorize the Matthew J. Morahan Health Assessment Center for Athletes ("MJM Center"), and Barnabas Health to disclose the Patient's health information described below to:

PEDIATRICIAN_____

PATIENT'S TEAM and/or SCHOOL STAFF OR REPRESENTATIVE: Tom Leahy (Athletic Director)/(Dr. Rosenblatt (School Physician Support)

ADDRESS AND/OR FAX NUMBER OF RECIPIENT (REQUIRED)_____

The Health Information described below is being disclosed for the following purpose:
To assess the Patient's ability to participate in sports activities and for related team and school purposes.

Information to be disclosed:
Results of all Cardiac Screenings, all Baseline Concussion Screenings and all Post Injury Concussion Testing on the Patient named above, which screening and/or testing were performed by, or sent to the MJM Center, and/or performed by or sent to Barnabas Health, during any dates before or after this form is signed.

This authorization will expire **four (4) years from the date of my signature below**, unless I otherwise specify that this authorization will terminate on the following date:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to the MJM Center Director. I understand that this revocation will not apply to the extent that Barnabas Health and the MJM Center have already released my information in reliance on this authorization.

I understand that this disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for treatment, enrollment or eligibility for health benefits, but I understand that in some cases, my school may not pay for tests performed by the MJM Center unless I release the results to the school. I understand that once my information has been disclosed to the school or team named above, health care provider privacy laws may no longer apply, and any disclosure of information carries with it the potential for an un-authorized re-disclosure by the recipient. If I have questions about the disclosure of my health information under this form, I can contact the MJM Center Director.

PATIENT SIGNATURE: _____ DATE:_____

If legal representative (e.g., parent or guardian of a minor), is signing below, please state relationship and authority to sign on behalf of patient.

SIGNATURE OF LEGAL REPRESENTATIVE/PARENT/GUARDIAN: _____

PRINT NAME OF LEGAL REPRESENTATIVE/PARENT/GUARDIAN:_____DATE:_____

RELATIONSHIP OF REPRESENTATIVE TO PATIENT: _____

PATIENT (OR REPRESENTATIVE OF MINORS) MUST BE GIVEN A COPY OF THE AUTHORIZATION FORM