Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Direction of Feed

Specialist Contact Information

Please answer every question

*Handwritten items must be entered **MANUALLY**. Do not fold this form.*

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

TESTS Have you had any of the following done recently?

Lab testing (within 30 days) — **DATE & LOCATION:**
yes no

EKG (within 6 months) — **DATE & LOCATION:**
yes no

Chest X-ray (within 6 months) — **DATE & LOCATION:**
yes no

CARDIOLOGIST (HEART DOCTOR)

Are you under the care of a Cardiologist? — **NAME, LOCATION & PHONE #:**
yes no

When was your last Cardiology visit?

Have you had a stress test (within the last 4 years)**?** — **LOCATION:**
yes no

PULMONOLOGIST (LUNG DOCTOR)

NAME, LOCATION & PHONE #:

Are you under the care of a Pulmonologist?
yes no

When was your last Pulmonology visit?

Have you had a Pulmonary function study? — **DATE & LOCATION:**
yes no

NEPHROLOGIST (KIDNEY DOCTOR)

Are you under the care of a Nephrologist? — **NAME, LOCATION & PHONE #:**
yes no

When was your last Nephrology visit?

Are you on dialysis? — **LOCATION:**
yes no

If you are on dialysis, how many times per week?
1 2 3 4 5 6 7

When was your last dialysis visit?

ENDOCRINOLOGIST (DIABETIC DOCTOR)

Are you diabetic?
yes no

Are you under the care of an Endocrinologist? — **NAME, LOCATION & PHONE #:**
yes no

When was your last Endocrinology visit?

INFECTION / RISK HISTORY Have you ever had any of the following?

MRSA
C. Difficile
IV Antibiotics
Immunosuppressive
Prednisone
Rejection Medications