ONKOLOGIE LERCHENFELD

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Innere Medizin - Hämatologie / Onkologie - Palliativmedizin

Dear patient,

thank you for asking for an appointment in our medical practice.

In order to assure a thourough and safe treatment we would like to ask for information about your medical history and previous treatments as well as medical reports if available. We also kindly ask for your declaration of consent enabling us to gather additional data about previous treatments and findings i.e. radiology & pathology reports if applicable.

1. **Medical History**
   - Previous treatments incl. surgeries, medication, allergies etc.

2. **Consent and authorization to obtain medical findings**
   - mandatory under data protection compliance
   - please inform us if medical data needs to be collected prior your first appointment

3. **Medical reports**
   - Surgery, Radiology, Histopathology, Laboratory, Epicrisis

   Please acknowledge several options for transmitting information:
   – bring reports along on first appointment
   – send reports via Fax or LifeTime prior first appointment (preferred, if possible)

4. **Insurance Card and Letter of referral**
   - Please have your medical insurance card and a letter of referral (if applicable) on hand

5. **Medication**
   - List of current medication

Please note: In case you do the registration in lieu of a third person, please do not forget to send the corresponding authorization. Due to data protection law any disclosure is warranted only with a valid authorization.

We are not allowed to give you any information without this authorization.

Please do not hesitate to ask for furher information or help,

Kindly,
ONKOLOGIE LERCHENFELD

Lerchenfeld 14, 22081 Hamburg - Tel: 040 / 22 71 80-0 - Fax: 040 / 22 71 80-67 - info@onkologie-lerchenfeld.de - www.onkologie-lerchenfeld.de
Kooperationspartner: UCCH Eppendorf - PCT-Alster - Ausbildungspraxis Asklepios Medical School Campus Hamburg
Nebenbetriebsstätte: Quartier 21

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Personal Data

Family Name (Surname)	First Name	Date of birth
Street, No.	Zip-Code, Place	Phone Home: Mobile:
Civil status / Children	Profession	Family Physician and/or referring specialist
Care degree	Degree of disability	height/weight
Relatives / Authorized proxy	Phone of relatives	Insurance

Reason for referral

☐ Diagnostics ☐ Therapy ☐ Follow-up/aftercare ☐ Second opinion

Diagnosis/Symptoms/Findings

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How did you find us?

☐ Family Physican/Specialist ☐ Referring Hospital

☐ Recommendation ☐ Internet

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Family name	First name	Date of birth

Medical History

	Yes	No	(date)		Yes	No	(date)
Blood pressure	☐	☐	_____	Liver disease/ Cirrhosis	☐	☐	_____
Diabetes	☐	☐	_____	Gall bladder & biliary tract disease	☐	☐	_____
Tuberculosis	☐	☐	_____	Hepatitis/Jaundice	☐	☐	_____
Lung disease	☐	☐	_____	Stomach disease	☐	☐	_____
Thyroid disease	☐	☐	_____	Bowl disease	☐	☐	_____
Increased Cholesterol	☐	☐	_____	Thrombosis / Pulmonary embolism	☐	☐	_____
Cardiac Arrthymias	☐	☐	_____	Bleeding tendency	☐	☐	_____
Coronary heart disease/ Myocardial infarction	☐	☐	_____	Stroke	☐	☐	_____
Congestive heart failure	☐	☐	_____	Epilepsy	☐	☐	_____
Chronic rheumatism	☐	☐	_____	Allergies	☐	☐	_____
Smoking habit (cig./day)	☐	☐	_____	Alcohol consumption (occasionally/regularly)	☐	☐	_____

List of medication

Description	morning noon evening night	
	☐ ☐ ☐ ☐	
	☐ ☐ ☐ ☐	
	☐ ☐ ☐ ☐	
	☐ ☐ ☐ ☐	

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Family name	First name	Date of birth

Surgeries

What kind of Surgery?	Reason	Month / Year

Family history (i.e. frequent diseases)

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Previous treatments in the context of the current disease
(Physicians, Hospitals, Diagnostics)

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Preventive checkup's
[months/ year]

Colonoscopy	
Gastroscopy	
Urology	
Gynaecology	
Mammography	

Family name	First name	Date of birth

Consent and authorization to obtain medical findings

I hereby declare consent, that the physicians of Onkologie Lerchenfeld may request medical information in written or electronical form, if applicabe via secured data transmission. Any obtained or transferred data is subject to medical confidentiality.

I have the right to revoke this consent at any time. My consent will automatically end in case treatment and care in Oncology Lerchenfeld is terminated. On request information about contaced institutions will be disclosed.

I also declare consent that Oncology Lerchenfeld will provide medical information to hospitals, clinics and cooperating physicians in case of regular enquiries and/or medical emergencies in order to optimize treatment and diagnostics.

Date	**Signature**

External service providers and cooperating institutions

Please acknowledge that we cooperate with external providers i.e. laboratories, consulting physicians, pharmacies , hospitals in order to coordinate your treatment. Any transmission of medical data is solely subject to facilitate and optimize your treatment.

I hereby declare consent, that the physicians of Onkologie Lerchenfeld transmit personal and medical information to external providers and cooperating physicians/institutions during my treatment in Oncology Lerchenfeld. I have the right to revoke this consent at any time. My consent will automatically end in case treatment and care in Oncology Lerchenfeld is terminated.

Date	**Signature**

Patient Service

I agree beeing contacted via telephone and/or electronically to update appointments.

Date	**Signature**