

Last Name/First/MI: _____ (Please print clearly)				Date of Service: _____		OFFICE USE ONLY	
Height: _____	Weight: _____	BMI: _____	Waist: _____	Date of Birth: _____	Age: _____		
						<input type="checkbox"/> Body	<input type="checkbox"/> Lung
						<input type="checkbox"/> Pelvis	<input type="checkbox"/> Colon
						<input type="checkbox"/> Carotid	<input type="checkbox"/> BMD
						<input type="checkbox"/> CIMT	<input type="checkbox"/> _____

Referring Physician _____

Have you had this test before? Yes No If yes, date _____ Score _____

Medical History (respond to all that apply):

Race: White/Caucasian African-American Hispanic/Latino American Indian Native Hawaiian/Pacific
 Indian (Asian) Asian _____ Other _____

Yes	No	Question?
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<input type="checkbox"/>	<input type="checkbox"/>	Have you had chest pain recently?
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<input type="checkbox"/>	<input type="checkbox"/>	Are you a diabetic? Type _____ Medication(s): _____
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<input type="checkbox"/>	<input type="checkbox"/>	Have high cholesterol? Medication(s): _____
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<input type="checkbox"/>	<input type="checkbox"/>	Have high blood pressure? Medication(s): _____
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<input type="checkbox"/>	<input type="checkbox"/>	Do you have any family history of heart disease? Family member: _____
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Lifestyle: Sedentary Active Stressful

Diet type: Regular, Mixed Low Fat Low Salt Vegetarian High Protein Other _____

Tobacco Use: Never Current Past-quit date: _____

Yes	No	Question?	Date?
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<input type="checkbox"/>	<input type="checkbox"/>	Have you had a stroke?	
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<input type="checkbox"/>	<input type="checkbox"/>	Have you had a heart attack?	
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<input type="checkbox"/>	<input type="checkbox"/>	Have you had heart angioplasty?	
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<input type="checkbox"/>	<input type="checkbox"/>	Do you have stents? # of Stents _____	
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<input type="checkbox"/>	<input type="checkbox"/>	Have you had bypass surgery? # of Grafts _____	
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<input type="checkbox"/>	<input type="checkbox"/>	Do you have any kidney disease?	
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<input type="checkbox"/>	<input type="checkbox"/>	Any known lung disease? <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other _____	
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<input type="checkbox"/>	<input type="checkbox"/>	Do you Exercise?	
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<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcohol? How much: _____ ounces per week	
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Any other Important Medical History: _____

For Staff Use Only

<p style="text-align: center;">INTERPRETATION</p> <p><input type="checkbox"/> NEGATIVE <input type="checkbox"/> LESS THAN <input type="checkbox"/> AVERAGE <input type="checkbox"/> GREATER THAN <input type="checkbox"/> MUCH GREATER THAN</p> <p>Comments: _____ _____</p> <p>By: <input type="checkbox"/> MB <input type="checkbox"/> RO <input type="checkbox"/> JC</p> <p>Initial: _____</p>	<p style="text-align: center;">Scanned _____ Consult _____ Scored _____</p> <p style="text-align: center;"># OF Score</p> <p>LM _____</p> <p>LAD _____</p> <p>CX _____</p> <p>RCA _____</p> <p>Total _____</p>	<p style="text-align: center;">ADMINISTRATION</p> <p>Charge _____</p> <p>RESEARCH STUDY _____</p> <p><input type="checkbox"/> PT FX <input type="checkbox"/> PT MAIL DATE: _____</p> <p><input type="checkbox"/> MD FX <input type="checkbox"/> MD MAIL DATE: _____</p> <p><input type="checkbox"/> IMAGE/CD MAILED: _____</p>
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Harbor-UCLA / Medical Foundation Inc. – Diagnostic & Wellness Center
Notice of Privacy Practices

Effective: April 14, 2003

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Our privacy practices:

♥ We maintain physical and electronic records and process safeguards to restrict unauthorized access to the health information of our clients, both past and present. These include secure office buildings, controlled computer network systems, and passwords.

♥ Other people that we do business with must also protect your health information if we must give it to them.

What do we mean by “health information?” Health information is information about you that is used to identify you, including your birth date, address, and social security number. This information is also anything about your past, present, or future medical condition, evaluation and treatment of any such condition, and related health services.

How we receive information about you: We receive information about our clients in several ways. Information is given from referring physicians, clinics, labs, and hospitals that may provide your medical care. Information is also given from employers, or benefit sponsor or associations, consumer or medical reporting agencies, or other third parties. Finally, from our affiliates and contracted medical groups.

How we may use and share information about you: We may share health information with doctors or hospitals to help them provide medical care for you. We may use information in your health record to judge the quality of health care you receive. We may also use this information in regulatory or other audits, in legal investigations, in our fraud and abuse program, when checking your eligibility, enrollment, and when checking the quality of the services we provide. We may use your health information to contact you with your appointment reminder, information about treatment alternatives or other health-related benefits and services that may be of service or interest to you.

Other uses of your health information: You or your doctor, hospital, and other health care providers may appeal or review the way we managed your care. Your health information may be used so that we can make decision about these appeals and grievances. We may share your health information with the federal government when it is checking on how we are meeting privacy rules. Sometimes a court of law will order us to give your health information to another person. We may also share your health information if otherwise required by law.

What are your privacy rights? You have the right to ask us not to share your health information in the ways described above. We may not be able to agree to your request. You have a right to ask us to contact you if you believe it is necessary for your safety. You or your personal representative has the right to get a copy of your health information. You have the right to ask that information in your record be amended if you believe it is not complete or correct. If we do not make the changes you ask for, you may ask that we review the decision.

How you can contact us to use your privacy rights: Diagnostic & Wellness Center – Medical Foundation Inc., 1124 W. Carson Street, Torrance, CA 90502, (310) 222-3844

Do you have a concern about your privacy?

If you believe that we have not protected your privacy and want to file a complaint with us, you may call us at the address and phone number shown below. You may also contact the US Department of Health Services by sending your concern to them in writing at the following location:

Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights
Attention: Regional Manager, 50 United Nations Plaza, Room 322, San Francisco, CA 94102

For additional information, call (800) 368-1019

Or

U.S. Office for Civil Rights at (866) OCR-PRIV (866) 627-7748, or (866) 788-4989 (TTY)

You will not be penalized for filing a complaint. You may also use your privacy rights without fear of being punished. Changes to notice of privacy practices: Diagnostic & Wellness Center/Medical Foundation Inc. must obey the notice currently in effect. We have the right to change these privacy practices.

Printed Name

Signature

Date

Signature refused/ Reason: _____