GEISINGER
HEALTH SYSTEM

Geisinger Health System
Remote Second Opinion Instructions

If you or a loved one wants to receive a Remote Second Opinion, please follow these instructions.

There are five (5) forms in this packet. Each form serves a specific purpose and is necessary to complete in order to receive your second opinion. Please print this instruction sheet and all forms in this packet, and then follow these steps for completing each designated form.

1. **Consultation Request Form**

   Before seeking a Remote Second Opinion from Geisinger Health System, you should discuss with your physician why you are interested in receiving this service. After reviewing our terms and conditions, complete the **Consultation Request Form** and have your physician sign it. We are unable to provide you with your Remote Second Opinion without your physician's written acknowledgement and permission.

2. **Remote Second Opinion Checklist**

   Review the **Remote Second Opinion Checklist** with your physician. This will help you determine which medical records or diagnostic reports are appropriate to send to Geisinger. After you have identified the appropriate documents, obtain a copy of those records.

   Please note that your physician's office and/or hospital may charge a fee for providing you with a copy of your records. Geisinger is not responsible for any fees charged by other providers or entities in assembling your medical records for a remote second opinion.

3. **New Patient History Questionnaire**

   Compete the **New Patient History Questionnaire** and include it with your applicable medical records.

4. **Patient Disclaimer Form**

   Carefully review, date and sign the **Patient Disclaimer Form**.

5. **Payment Authorization Form**

   Complete the **Payment Authorization Form**, and then print, sign and include it with your medical records. This form must be completed in order for you to receive your Remote Second Opinion. If payment authorization is not provided, Geisinger does not assume responsibility for fees charged by other health care providers in assembling your medical records for a Remote Second Opinion.

Questions

If you have any questions, please contact us at 1.855.789.2468. We are happy to help you.

For Submission to Geisinger: Verify that each form is complete, and then package the following documents for shipping:

- Consultation Request Form
- New Patient Medical History Questionnaire
- Patient Disclaimer Form
- Payment Authorization Form

- All applicable medical records, and/or pathology reports

Send the package to:

Geisinger Health System
Attn: Tess Mordan, RN
Destination Nurse Navigator
100 N. Academy Avenue
M.C. 27-66
Danville, PA 17822-2766

We recommend all correspondence be sent via a courier (FedEx, UPS, DHL, registered US Postal Mail, etc.) that tracks the delivery of packages and requires a signature when the package arrives at Geisinger. As the patient, you assume all liability related to the decision to use a particular courier or mail service.

Within 10 business days of receipt of all information (forms and medical records), a Geisinger physician will mail written reports to you and your physician who authorized your Remote Second Opinion. Upon request, the Geisinger physician who completed your Remote Second Opinion will be available for a phone call with you and your physician, to discuss your Remote Second opinion and answer any questions.

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Geisinger Health System
Remote Second Opinion

Consultation Request Form

Name of Patient: _____

I request Geisinger Health System to provide a remote second opinion for the above-named patient. My patient and I have discussed this request and understand the risks and limitations of this service. I agree to provide my patient with copies of their medical records and any other relevant diagnostic reports or studies. I also understand I will receive a copy of the assessment and recommendation and will review it with the above-named patient as I deem appropriate. I also acknowledge that I am a licensed physician in the state in which my practice is located AND in which the patient resides.

PHYSICIAN SIGNATURE _____DATE: ____ / ____ / ____

(Please Print)
Treating/Referring Physician Name:
_____

Name of Practice:
_____

Street Address: _____

Suite: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ - _____ Office Fax: (_____) _____ - _____

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Geisinger Health System Dermatology
Remote Second Opinion

Checklist

The following list of items is needed to provide you with the best assessment and recommendation:

Required Forms

- Patient Disclaimer (authorized signature required)
- Consultation Request Form (signed by your local physician)
- Payment Authorization Form (authorized signature required)
- New Patient History Questionnaire (authorized signature required)

If any of the following tests have been performed, copies of the test (hard copy or disc) **and** their official readings or reports are needed in order to process your request:

- High quality picture of the mole or area you are requesting consultation
- Tissue processing results (if available)
- Tumor histology (if applicable/ available)
- Most recent blood tests
- Any radiologic studies such as x-rays, MRI's or CT scans

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Geisinger Health System Department of Dermatology
New Patient History Questionnaire

DEAR PATIENT:

Welcome to the Department of Dermatology at Geisinger Health System. We ask that you fill out this form as part of the second opinion process. Please complete this questionnaire to the best of your ability. This questionnaire will allow the doctor to get to know more about you, your medical condition, your family and your habits. This questionnaire is confidential and will be kept as part of your medical record. If you have any questions about issues of confidentiality, please feel free to contact our Nurse Navigator for clarification at 1-(855) 789-2468.

First Name: _____ M.I.: _____ Last Name: _____

PERSONAL INFORMATION (REQUIRED)

Date of Birth: ____ / ____ / _____ Social Security Number: _____ - ___ - _____

Mother's Maiden Name: _____ Father's Name: _____

CONTACT INFORMATION (REQUIRED)

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____
Is it okay to contact you at work: Yes No

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Email:_____

MEDICAL QUESTIONS (REQUIRED)

What diagnosis/ disease/ disorder are in question? _____
_____

What specific questions would you like to have addressed during the remote second opinion?

_____
_____
_____

_____
_____

What do you hope to gain by engaging the services of a remote second opinion?

_____
_____
_____
_____

<u>WHO REFERRED YOU TO OUR OFFICE</u>?

Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Specialty: _____

<u>PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT</u>:

Name: _____

Address: _____

Phone: _____ Fax : _____

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

HISTORY OF PRESENT ILLNESS:

1. What is the reason for your visit today? _____

2. How long have you had the problem? _____

3. How severe is the problem? _____

4. What type of symptoms are you experiencing? _____

5. How often do the symptoms occur? _____

6. How long do the symptoms last? _____

7. Does anything make the problem better? _____

8. Does anything make the problem worse? _____

9. Have you ever had treatment or surgery for this problem? _____

10. Please rate your pain on a scale from 0 (no pain) to 10 (worst imaginable). _____

REVIEW OF SYSTEMS:
Please circle and provide brief details for the medical conditions below that apply to you now.

GENERAL
Weight loss or gain
Change in appetite
Altered taste or smell
Excessive sleepiness
Unable to sleep
Fatigue

EYE
Blurred vision
Double vision
Glaucoma
Cataracts

CARDIOVASCULAR
Chest pain
Chest pressure
Angina
Fainting
Leg swelling
High blood pressure
Low blood pressure
Heart Murmur
Heart Failure
Shortness of breath

EARS, NOSE, MOUTH, THROAT
Balance problems
Trouble breathing
Sinus disease
Mouth sores
Trouble swallowing
Sore Throat
Ringing in ears
Dizziness
Hearing loss

RESPIRATORY
Emphysema
COPD
Tuberculosis
Chronic cough
Bronchitis
Pneumonia

GASTROINTESTINAL
Ulcer
Hepatitis
Vomiting
Constipation
Diarrhea
Bowel incontinence
Gastritis
Hiatal hernia
Rectal bleeding

GENITOURINARY
Kidney Stones
Urinary urgency
Urinary incontinence
Sexual dysfunction
Impotence
Vaginal bleeding
Painful urination
Frequent urination
Blood in urine

PSYCHIATRIC
Depression
Anxiety
Trouble concentrating

INTEGUMENTARY
Skin rash

NEUROLOGICAL
Headache
Seizure
Loss of consciousness
Memory loss
Weakness
Trouble walking
Trouble with balance
Numbness
Tingling
Concussion
Falls
Vertigo

MUSCULOSKELETAL
Low back pain
Neck pain
Joint pain
Joint swelling

ENDOCRINE
Diabetes
Thyroid Disease

HEMATOLOGICAL
Blood disorder
Leukemia
Sickle Cell Disease
Enlarged lymph nodes
HIV

PAST MEDICAL HISTORY:
Please list all current medical problems as well as major illness you have had in the past. Provide approximate dates.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PAST SURGICAL HISTORY:
Please list all operations you have had in the past. Provide approximate dates.

1. _____

2. _____

3. _____

4. _____

5. _____

Have you ever had a problem with anesthesia? _____ If yes, please explain. _____

Have you ever had a blood transfusion? _____ If yes, why? _____

MEDICATIONS:
Please list all medications you are currently taking, including over the counter medications, with dosage.

1. _____

2. _____

3. _____

4. _____

5. _____

Do you take aspirin or any medicines that contain aspirin, or pain relievers like ibuprofen or Motrin? _____
If yes, please specify. _____

ALLERGIES:
Please list any known drug and food allergies:

1. _____

2. _____

FAMILY HISTORY:

Please list all medical problems and current age of the following family members. If they are deceased, please list the cause and approximate age of death.

Grandparents: _____ Aunts: _____

_____ _____

_____ Uncles: _____

_____ _____

Father: _____ Mother: _____

Brothers: _____

Sisters: _____

Children: _____

Grandchildren: _____

SOCIAL HISTORY:

What is your highest level of education? _____

What is your occupation? _____

Are you disabled? _____

Was the injury due to a work-related accident? _____

Was the injury due to a non-work-related injury? _____

Was the illness/injury caused by an automobile accident? _____

Was another party responsible for this accident? _____

Is there any litigation involved? _____ If yes, please explain. _____

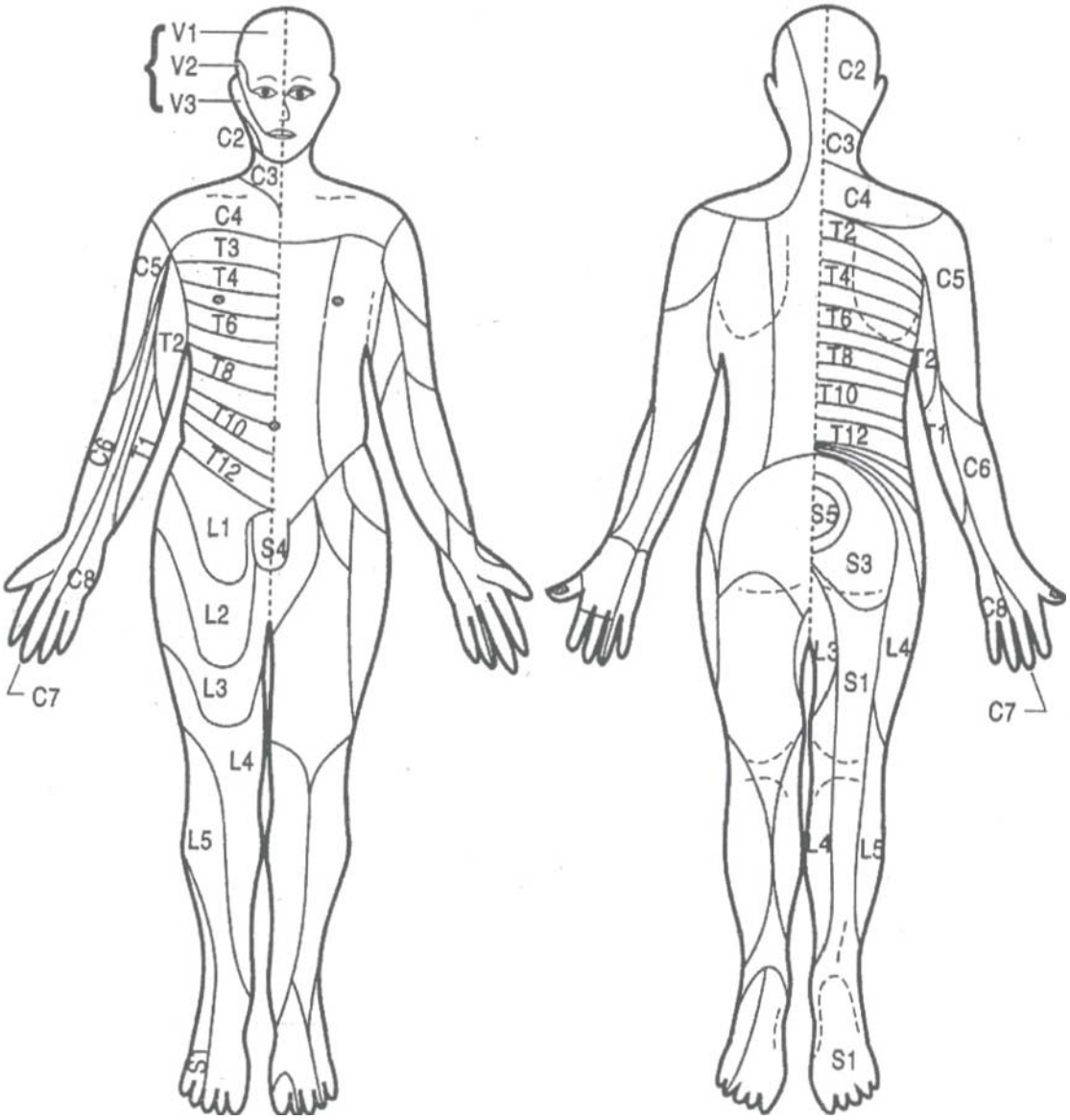
Do you smoke? _____ If yes, how much and for how long? _____

If you quit, when did you quit? _____

Do you drink alcohol? _____ If yes, approximately how many drinks per week?_____

Please mark and describe any skin abnormalities and provide a brief description of your concerns.

Anterior **Posterior**



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Geisinger Health System
Remote Second Opinion

Patient Disclaimer

By using the Geisinger Remote Second Opinion, you agree to abide by the Terms and Conditions posted at our website including particularly the terms and conditions described below:

CONSULTATIVE SERVICE
The service provided through the Geisinger Remote Second Opinion is different from the diagnostic services typically provided by a physician. The Geisinger physicians providing this service will not have the benefit of information that would be obtained by examining you in person and observing your physical condition.

Therefore, the physician may not be aware of facts or information that would affect his or her opinion of your diagnosis. Because this is a limitation on the accuracy of his or her opinion, and this is a risk to you, the recommendations of the Geisinger physician will be shared with your local physician. By deciding to engage this service, you acknowledge and agree that you are aware of this limitation and agree to assume the risk of this limitation.

By requesting a Remote Second Opinion, you acknowledge and agree that:
• The diagnosis you will receive is limited and provisional;
• The Remote Second Opinion is not intended to replace a full medical evaluation or a face-to-face visit with a physician;
• The Geisinger physician does not have important information that is usually obtained through a physical examination; and,
• The absence of a physical examination may affect the Geisinger physician's ability to diagnose your condition, disease or injury.

By engaging our services, you acknowledge and agree to assume the risk of these limitations. You further understand that no warranty or guarantee has been made to you concerning any particular result or cure of your condition.

_____ ___ / ___ / ___
Patient Signature Date

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Geisinger Health System
Remote Second Opinion: Department of Dermatology

Payment Authorization

SERVICES REQUESTED

_____ Dermatology Remote Second Opinion $450
_____Pathology Interpretation (add'l $180 per interpretation) $_____

Total $ _____

Method of Payment: ___ VISA____Mastercard___Discover____American Express

				--					--					--				

Expiration Date			--		

Security Code			

Name (as it appears on your credit card)

-

Address_____Apt _____

CITY _____STATE _____ ZIP _____

I authorize Geisinger Health System to charge the above amount for services requested through the Remote Second Opinion Program. I acknowledge that I am an authorized user of this credit card and assume the risks and liabilities associated with its use.

SIGNATURE_____DATE:____/___/___

FOR OFFICE USE ONLY

Medical Record Number (MRN)								

Geisinger Physician's Name:

- Specialty Dept: _____
- Pathology Dept: _____

Date of Service: ____/__/___