Neuropsychological Testing Appointment Information

Your upcoming appointment will be with ____.

Broadway Medical Building	**Legacy Ridge Medical Building**	**Saint Luke's South–Neurology**
4400 Broadway Blvd, Suite 316 Kansas City, MO 64111	301 NE Mulberry St., Suite 200 Lee's Summit, MO 64086	12330 Metcalf Avenue, Suite 420 Overland Park, KS 66213

Visit Date/Time:

____

Co-payment/Pre-payment amount:

$ ________________________

Arrival Time:

____

Late arrivals may result in the rescheduling of your appointment.

Initial Visit Checklist:

- ☐ Bring the attached paperwork **FULLY COMPLETED** with you to your appointment.
- ☐ If there are memory or cognition concerns, we request you bring one family member or caregiver with you.
- ☐ Bring a **current list** of your medications and allergies or update on mySaintLuke's Portal before arriving.
- ☐ Please make sure you bring any assistive devices, medical equipment, or medicine you may need such as eyeglasses, hearing aids, a glucometer, wheelchair, walker, etc.
- ☐ Be prepared to pay the copayment/pre-payment amount listed above prior to your appointment.
- ☐ It is helpful if you complete the eCheck-in and pay your copay through the mySaintLuke's Portal before arriving.

If for any reason you are unable to keep this appointment or have any questions regarding this appointment, please contact our office at **816-932-1711** or **816-932-1727** to reschedule.

saintlukeskc.org

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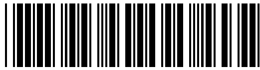
Saint Luke's Health System 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。



Saint Luke's Health System
Saint Luke's Physician Group

Informed Consent for Neuropsychological Assessment

Patient name:____**DOB:**__________

Nature, Purpose, and Benefits of Assessment: The goal of neuropsychological assessment is to determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive functions. A neuropsychological assessment may point to changes in brain function and suggest possible diagnoses as well as methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your background and current medical and psychological symptoms, we may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, viewing printed material, and manipulating objects.

Foreseeable Risks and Discomforts: For some individuals assessments can cause fatigue, frustration, and anxiousness. Other risks are generally minimal and can include headaches or mild discomfort from sitting.

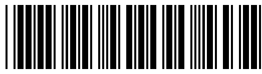
Time Commitment: Assessments consist of an interview lasting 30-60 minutes and 2-3 hours or more of face-to-face testing and several additional hours for scoring, interpretation, and report preparation. This evaluation is estimated to take approximately ____ hours of face-to-face assessment time.

Limits of Confidentiality: Information obtained during assessments is confidential and will be shared only with your referring provider. As our medical records are electronic, other Saint Luke's providers involved in your care will also be able to review the written report if they have a legitimate reason to do so. Information can otherwise ordinarily only be released only with the written permission of you or your designated legal representative. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law.

☐ I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing. I acknowledge that no guarantee has been made to me as to the results. I hereby authorize the providers of Saint Luke's Neuropsychology and whomever he/she may designate as his/her legal representative to conduct the evaluation.

DATE:____________**TIME:**___________**A.M. P.M.**

Patient Label:



Saint Luke's Health System
Saint Luke's Physician Group

Informed Consent for Neuropsychological Assessment

Where patient is incapable of signing and another person signs in his stead, fill in the following information:

State why patient is not able to give consent personally (or to sign this form).

Explain: ☐ Minor ☐ Unconscious ☐ Other

____
Signature of witness Date Time

____
Signature of witness Date Time
(Phone permission requires two witnesses)

____
Patient/ Other legally responsible signature Date Time
(e.g., legally appointed guardian or Public Administrator)

Relation of signer to patient:____

Address of Witness(es):____
____
____

Prior to the time of the procedure above described, I explained to the patient named above and to any person who has consented to the procedure on the patient's behalf, the nature, purpose, benefits, and risks of the procedure as stated as well as possible alternative methods of treatment. I have further discussed possible consequences of the procedure, the principal risks involved, and possible complications.

____
Physician/Provider Date Time

Patient Label:

Patient Registration Form

(Please Print)

Patient Demographics:

Last Name: __________________________ **First Name:** _________________________ **MI:** ____________

Preferred Name: ______________________ **Birth Date:** _________________ SSN: ____________________

Sex assigned at Birth: **Male** **Female** **Gender Identity:** ______________________

Address: ____

City/State/Zip: ____ **County:** ___________________________

Home Phone: _________________ **Cell Phone:** _________________ **Work Phone:** ____________________

Email: ____

Birth Place: _____________________________________ **United States Citizen:** **Yes** **No**

Marital Status: **Single** **Married** **Divorced** **Legally Separated** **Widowed** **Other**

Patient Language: **English** **Spanish** **Other**______________ **Interpreter Needed:** **Yes** **No**

Ethnic Group: **Hispanic or Latino** **Not Hispanic or Latino** **Decline**

Race: **American Indian or Alaska Native** **Black or African American** **White or Caucasian**

Asian **Native Hawaiian or Other Pacific Islander** **Other** **Decline**

Religion: ____________________________ **Place of Worship:** ____________________________

Education: ________________________________

Patient Primary Care Physician Information:

Primary Care Physician: _______________________________________ **Phone:** _______________________

Practice Location/Address: ____

Patient Employment Information:

Employment Status: **Full Time** **Part Time** **Self-Employed** **Full Time/Student** **Part Time/Student**

Military Duty **Not Employed** **Disabled** **Retired**

Employer: ________________________________

Initial Health History Packet

Saint Luke's Neuropsychology Division

Broadway Medical Plaza
4400 Broadway Blvd,
Suite 316
Kansas City, MO 64111

Legacy Ridge Medical Plaza
301 NE Mulberry,
Suite 200
Lee's Summit, MO 64086

Saint Luke's South – Neurology
12330 Metcalf Avenue,
Suite 420
Overland Park, KS 66213

GENERAL INFORMATION

Name: ______________________________________ DOB: ____________

Education level: __________________________

Reason for visit: ____

Referring doctor: ____

Thank you for taking time to fill out these forms. Please answer these questions to the best of your knowledge.

PSYCHIATRIC HISTORY

Have you ever been diagnosed with any of the following disorders?

Mood Disorders	**Psychotic Disorders**
Major Depression	Schizophrenia
Postpartum Depression	Schizoaffective Disorder
Dysthymic Disorder	Any other Psychotic Disorder
PMS/Premenstrual Depression	**Eating Disorders**
Bipolar Disorder/Manic Depression	Anorexia Nervosa
Anxiety Disorders	Bulimia Nervosa
Generalized Anxiety Disorder	Any other Eating Disorder
Panic Disorder	**Substance Use Disorders**
Obsessive Compulsive Disorder	Alcohol abuse or dependence
Social Anxiety Disorder	Cocaine abuse or dependence
Post-Traumatic Stress Disorder (PTSD)	Opiate abuse or dependence
Any other Anxiety Disorder	Any other substance abuse Disorder
Personality Disorder	**Other Disorders**
Antisocial Personality Disorder	Attention Deficit Hyperactivity Disorder
Borderline Personality Disorder	Migraine Headaches
Any other Personality Disorder	Seizure Disorder/Epilepsy
	Other, please specify:

Please list any past or current Psychiatrist, Psychologist or Mental Health Provider (name/address/phone number):

____

____

Please list any other doctors/specialists you see regularly (name, address, phone number)

____

____

Please list all current prescription, over the counter medications, vitamins and their dosages that you are currently taking:

Medication/Vitamin/Supplement	Dosage	Timing (in the morning, how many times per day)

Do you currently:

Smoke? _____ **If yes, how much? ____**

Drink alcohol? _____ **If yes, how much? ____**

Please mark if you have experienced any of the following:

General				**Genitourinary**		
Appetite loss	Yes	No		Pain with urination	Yes	No
Weight loss/gain	Yes	No		Frequent urination	Yes	No
Fever/Chills	Yes	No		Difficulty starting or maintaining urine stream	Yes	No
				Sexual difficulties	Yes	No
EENT						
Hearing loss	Yes	No		**Musculoskeletal**		
Vision change	Yes	No		Muscle pain	Yes	No
Nasal congestion	Yes	No		Joint pain	Yes	No
Trouble swallowing	Yes	No		Back pain	Yes	No
Cardiovascular				**Skin**		

Chest pain	Yes	No		Rash	Yes	No
Shortness of breath	Yes	No		Itching	Yes	No
Swelling in hands or feet	Yes	No				
				Neurologic		
Respiratory				Headaches	Yes	No
Cough	Yes	No		Dizziness	Yes	No
Wheezing	Yes	No		Falls	Yes	No
				Tremor/shaking	Yes	No
Gastrointestinal				Weakness	Yes	No
Nausea	Yes	No		Numbness	Yes	No
Vomiting	Yes	No				
diarrhea	Yes	No		**Endocrine**		
constipation	Yes	No		Feeling hot or cold	Yes	No
heartburn	Yes	No		Excessive thirst or urination	Yes	No
Hematologic	Yes	No		**Psychiatric**		
Abnormal bruising	Yes	No		Depression	Yes	No
Abnormal bleeding	Yes	No		Anxiety	Yes	No
				Hallucinations	Yes	No

FAMILY PSYCHIATRIC HISTORY

Have any of your family members been diagnosed with any mental illness, substance abuse disorder, dementia, or neurologic disorder? Please specify

____

____

____

OTHER CONCERNS:

Is there anything else that you would like to tell us?

____

____

____

____

____

To be filled out
by patient
ONLY

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T____* = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

To be filled out by patient **ONLY**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________ **DATE:**______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	
	TOTAL:			

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.