APS Wound Care

1328 Papermill Pointe Way
Knoxville, Tn. 37909
Phone: 865-288-8947

Date: ______________
Account#: ______________

Appointment Policy and Check-In Policy

- ☐ If you are more than 15 minutes late for your appointment, you will not be seen for your appointment time, and you will be rescheduled for the next available time. If you are determined to be a no show / no call more than 3 times you will be dismissed from the program.
- ☐ **NO ONE** is permitted in the exam room during your scheduled visit. Exceptions to this policy will be reviewed on a case by case basis. Examples include wheelchair dependent individuals, language / cultural barriers, slow or delayed cognitive abilities, inability to read or write, hard of hearing, or poor historian.
- ☐ Children under the age of 18 are not permitted in the exam rooms and are not permitted to remain in the lobby unattended. **There are no exceptions to this policy, appointments will be rescheduled.**

Patient signature: Date:

Release of information to family and friends

I authorize and allow APS Wound Care to release and discuss my medical and billing information to the following individuals and physicians:

Primary care physician:

Name: Relationship to patient Phone #

Consent for photo documentation

Patient understands and consents that images (digital, film, etc.), will be taken of the all wound(s) present with their surrounding anatomical features. Patient understands and consents that these images (digital, film, etc) may be used for educational (initial) ______________ and marketing (initial) ______________ purposes, images that could potentially identify the patient will automatically be discluded from use. Patient further agrees that the referring physician or other treating physicians may receive communications, including these images, regarding the patient's treatment plan and results. The images are considered part of the medical records and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. Patient understands that APS Wound Care will retain the ownership rights of these images, but that the patient will be allowed access to view images upon written request. Patient understands that these images will be stored in a secured manner that will protect privacy and that will be kept for the period required by law. Patient waives any and all rights, royalties or other compensation for these images. Images that identify the patient will only be released upon written authorization by the patient or his or her legal representative.

Patient signature: Date:

APS Wound Care
New patient questionnaire and history

Patient name: ______
Date: ______
Chart#: ______

Demographics:

Name:	Date of birth: Age:
Address:	
City:	State: Zip:
Phone #:	E-mail:
Emergency contact:	Gender:

Social history:

Do you live alone?:	Do you drive?:	Employed:
Highest level of education:	Financial concerns:	Support system intact:
Do you smoke?:	If so, how many packs per day?:	Do you want to quit?:
Do you drink alcohol?:	If so, how often?:	Type:
Caffeine use?:	How many cups per day?:	
Transportation concerns:	Food / clothing / shelter concerns:	Hygiene concerns:

Physician history:

Primary care provider	Phone #:
Cardiologist:	Phone #:
Endocrinologist:	Phone #:
Specialist:	Phone #:

Additional contact information:

Home health agency:	Phone #:
Skilled nursing facility:	Phone #:
Pharmacy:	Phone #:
Pharmacy:	Phone #:

Do you have the following?:

Advanced directives:	Living Will:	Medical power of attorney: If yes, who:	DNR:

Name of person completing form if not the patient:

Signature: Date:

Reviewed by: Date:

Patient name:
Date:
Chart#:

Wound history:

Wound location:	
When did you first notice the wound?:	Has it ever healed?:
How did your wound start?: (circle) Bite Blister Bump Surgery Gradually appeared Radiation / thermal / chemical burn Swelling	Footwear Pressure Weeping Puncture Trauma / scratch
How have you been cleaning and treating the wound?:	
Have you been tested for bacteria by a physician?:	Where antibiotics ordered?:
Have you ever had an infection in the bone?:	When and where?:

Medical history: (circle yes or no as it pertains to your medical history, not family)

Condition		Condition	
Anemia	Yes / no	Thyroid disease	Yes / no
Hemophilia	Yes / no	Type 1 diabetes	Yes / no
HIV / Hepatitis	Yes / no	Type 2 diabetes	Yes / no
Lymphedema	Yes / no	Currently taking insulin	Yes / no
Sickle cell disease	Yes / no	End stage renal disease	Yes / no
COPD / Emphysema / Oxygen use	Yes / no	Dialysis (Type:)	Yes / no
Congestive heart failure	Yes / no	Lupus	Yes / no
Coronary artery disease	Yes / no	Scleroderma	Yes / no
Peripheral vascular disease	Yes / no	Psoriatic arthritis	Yes / no
Peripheral arterial disease	Yes / no	Osteoarthritis	Yes / no
Atrial fib or irregular heart beat	Yes / no	Neuropathy	Yes / no
Heart attack	Yes / no	Paraplegia	Yes / no
Hypertension	Yes / no	Quadriplegia	Yes / no
Vasculitis / Phlebitis	Yes / no	Receiving chemotherapy	Yes / no
Deep vein thrombosis	Yes / no	History of radiation therapy	Yes / no
Currently taking blood thinners	Yes / no	Dementia	Yes / no

Name of person completing form if not the patient:

Signature: Date:

Reviewed by: Date:

Patient name: ____________
Date: ____________
Chart#: ____________

Are you currently experiencing any of the following symptoms?:

Recent weight loss	Yes / no	Spitting up blood	Yes / no
Fever	Yes / no	Shortness of breath	Yes / no
Fatigue	Yes / no	Loss of appetite	Yes / no
Nose bleeds	Yes / no	Nausea or vomiting	Yes / no
Mouth sores	Yes / no	Coughing when you swallow	Yes / no
Bleeding gums	Yes / no	Difficulty swallowing	Yes / no
Chest pain	Yes / no	Rash or itching	Yes / no
Palpitations	Yes / no	Changes in hair or nails	Yes / no
Increased swelling of the limbs	Yes / no	Lightheadedness / dizziness	Yes / no
Cold extremities	Yes / no	Tremors	Yes / no
Aching legs at night	Yes / no	Numbness / tingling	Yes / no
Discoloration of the toes or feet	Yes / no	Dry skin	Yes / no
Easily bleed or bruise	Yes / no	Heat or cold intolerance	Yes / no
Frequent coughing	Yes / no	Excessive thirst	Yes / no

Have you been recently hospitalized?:

If yes when and where:	What for?:

For healthcare provider Use only:

Name of person completing form if not the patient:

Signature: Date:

Reviewed by: Date:

Patient name:
Date:
Chart#:

If you cannot provide a complete list of your medications please fill out the section below. Please include any vitamins or herbal supplements that you are taking.

Medication name:	Dosage:	Frequency:	Purpose:

Name of person completing form if not the patient:

Signature: Date:

Reviewed by: Date:

Nutritional Assessment Questionnaire

Patient Name: _______________ DOB: ________
Sex: ________ Height :_______ Weight: _______

Please read each question in its entirety and answer to the best of your ability. Circle each answer.

1. Have you changed the kind of food or amount of food that you eat due to illness or medical condition? Yes / No
2. Do you eat fewer than 2 meals each day? Yes / No
3. Do you eat fruits, vegetables and drink milk every day? Yes /No
4. Do you have any tooth or mouth problems that make it hard to eat certain foods? Yes / No
5. Do you eat alone most of the time? Yes / No
6. Do you have the financial means to obtain food? Yes / No
7. Do you take 3 or more prescribed or over the counter medications per day? Yes / No
8. Have you lost or gained over 10 pounds in the past 6 months without trying? Yes / No
9. Are you physically able to shop, cook and feed yourself? Yes / No
10. Do you have any medical conditions that affect your ability to absorb nutrients? Yes / No

Please circle the answer that best answers the following questions.

1. My appetite is...
   a. Very poor
   b. Poor
   c. Average
   d. Good
   e. Excellent
2. When I eat...
   a. I feel full after eating only a few mouthful
   b. I feel full after eating about a third of a m
   c. I feel full after eating over half a meal
   d. I feel full after eating most of the meal
   e. I hardly ever feel full
3. I feel hungry...
   a. rarely
   b. occasionally
   c. some of the time
   d. most of the time
   e. all of the time
4. Food tastes...
   a. very bad
   b. bad
   c. average
   d. good
   e. very good
5. Compared to when I was younger, food tastes...
   a. much worse
   b. worse
   c. just as good
   d. better
   e. much better
6. Normally I eat...
   a. less than one meal a day
   b. one meal a day
   c. two meals a day
   d. three meals a day
   e. more than three meals a day
7. I feel sick or nauseated when I eat...
   a. most times
   b. often
   c. sometimes
   d. rarely
   e. never
8. Most of the time my mood is...
   a. very sad
   b. sad
   c. neither sad nor happy
   d. happy
   e. very happy

Results based upon the following numerical scale: a = 1, b = 2, c = 3, d = 4, e = 5.
CNAQ score ≤ 28 indicates significant risk of at least 5% weight loss within six months.
SNAQ score ≤ 14 indicates significant risk of at least 5% weight loss within six months.