PATIENT INFORMATION/HISTORY FORM

INSTITUTE OF NEUROLOGICAL RECOVERY®
INR PLLC
2300 GLADES ROAD, SUITE 305E, BOCA RATON, FL 33431

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. ALL INFORMATION WILL REMAIN CONFIDENTIAL. **(Potential patient or caregiver may fill this form out.)**

I. POTENTIAL PATIENT INFORMATION

Today's Date: _____

Name: First _____ Mid. Init. _____ Last _____

Home Address: _____

City/State/Zip: _____

Date of Birth: _____ **Age**: _____ **Social Security No.**: _____

Email Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Primary Caregiver: _____ **Relationship to Patient**: _____

How did you hear about us?: _____

PLEASE SELECT "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

YES NO

◯ ◯ Does the patient live with the caregiver? If the answer is NO, please describe the current living arrangement of the patient: _____

◯ ◯ Can the patient walk? If yes, is it: ◯ With a Walker/Cane OR ◯ Without assistance

II. DIAGNOSIS/PHYSICIAN/PRIMARY MD

Date of Traumatic Brain Injury: _____

PLEASE LIST THE NAME, LOCATION, AND PHONE NUMBER OF THE <u>NEUROLOGIST</u> WHO DIAGNOSED TRAUMATIC BRAIN INJURY:

NAME: _____ LOCATION: _____

TELEPHONE: _____ SPECIALTY: _____

PLEASE LIST THE NAME, LOCATION, AND PHONE NUMBER OF THE <u>PRIMARY MD</u>:

NAME: _____ LOCATION: _____

TELEPHONE: _____

III. GENERAL MEDICAL HISTORY

PLEASE LIST ALL CURRENT MEDICAL CONDITIONS AND ALLERGIES:

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES:

Name of Medication	Dosage	How Many Pills Per Day?	Date Started?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IV. SPECIFIC MEDICAL HISTORY: DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? Please select "Yes" or "No"

No	Yes		No	Yes	
○	○	Multiple sclerosis	○	○	Uncontrolled Diabetes Mellitus
○	○	Other demyelinating disease (i.e. optic neuritis)	○	○	HIV
○	○	Congestive Heart Failure	○	○	Blood Disorder/Lymphoma
○	○	Active infection	○	○	Hepatitus
○	○	Bleeding Disorder	○	○	Immunosuppression
			○	○	Tuberculosis or positive PPD test

Policy Statement: The anti-TNF medications used are FDA-approved for certain medical indications, but are not approved at this time for Traumatic Brain Injury. I understand that the INR PLLC physicians have completed residencies in Internal Medicine. I understand that the treatment offered is not research. I understand that I am responsible for any charges I may incur at the Institute of Neurological Recovery INR PLLC.

POTENTIAL PATIENT: _____DATE: _____

CAREGIVER: _____DATE: _____

For Physician's Use Only: **I have reviewed the above information and believe this patient is a candidate for medical evaluation to determine and discuss his/her suitability for anti-TNF treatment for his/her individual condition.**

YES **NO** PHYSICIAN SIGNATURE: _____ **DATE:** _____

Directions:
Please fill out the above information by typing directly into this form on your computer, or printing the form and then filling it out by hand. Then please send this form to the INR by one of the following methods:

1. Please click the **Submit Form** button at the top upper right of the form. You may then e-mail the form using your e-mail application, or attach it using web-based e-mail, to inrboca@gmail.com;
2. Please fax this document, without a cover sheet, to (561) 372-7874.

If you need help with this form please contact the Institute at (561) 353-9707.