BU Physical Therapy Center

Full Name: _____

Date of Birth: _____

Preferred Name: _____ Pronouns:_____ Occupation: _____

History of Present Condition

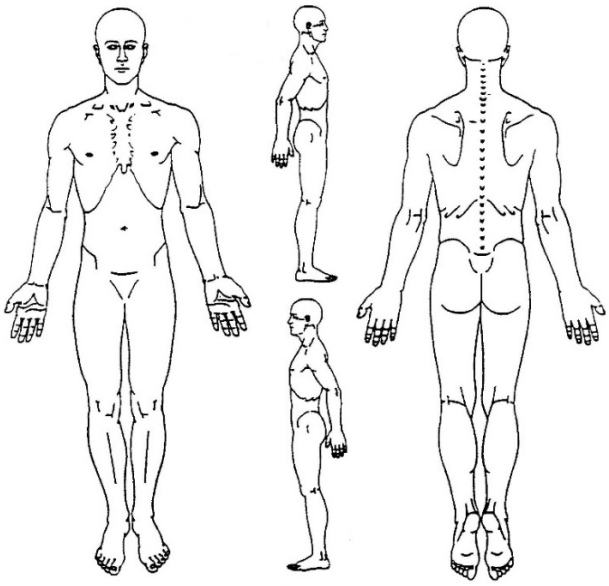
What are your current Symptoms?_____

When did your current symptoms begin?_____ ☐Sudden Onset ☐Gradual onset

How did it occur? (ex. Fall, Accident…) _____

What functional problems do you have with this condition? _____

Using the diagram please circle the area of pain or abnormal sensation: *(If completing electronically, leave this BLANK)*



What type of symptoms do you have? Check all that apply: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Numbness ☐ Tingling ☐ Shooting ☐Other_____

Pain Severity: Using the scale below 0=no pain, 10= severe pain, please circle the number that best applies:

Today: **No Pain** **0 1 2 3 4 5 6 7 8 9 10** **Severe Pain**

Best you have felt: **No Pain** **0 1 2 3 4 5 6 7 8 9 10** **Severe Pain**

Worst: **No Pain** **0 1 2 3 4 5 6 7 8 9 10** **Severe Pain**

What activities make your pain worse:_____

What activities seem to ease your pain:_____

Since onset, are your symptoms (*Choose One*): ☐Getting Better ☐Getting Worse ☐Not Changing

Does the pain wake you at night? ☐No ☐Yes

If yes, is it present: ☐ While lying still ☐ Only when changing positions ☐ Both

General Health and Past Medical History

Sleep Quality

Describe your sleep quantity (avg per night) and quality: _____

Have you ever been diagnosed/treated for any of the following disorders? Check all that apply:

Chronic Fatique Syndrome ☐YES ☐NO	Temporomandibular Syndrome ☐YES ☐NO	Irritable Bowel Syndrome ☐YES ☐NO
Fibromyalgia ☐YES ☐NO	Neck Injury(including whiplash) ☐YES ☐NO	Multiple Chemical Sensitivities ☐YES ☐NO
Migraines/Tension Headaches ☐YES ☐NO	Restless Leg Syndrome ☐YES ☐NO	Anxiety Disorder/Panic Attacks ☐YES ☐NO
		Depression ☐YES ☐NO

Have you **EVER** been diagnosed/treated for any of the following conditions?

◯YES ◯NO	Cancer? If YES, what kind: _____
◯YES ◯NO	Heart Problems. If YES, what kind: _____
◯YES ◯NO	High blood pressure
◯YES ◯NO	Stroke/Bleeding Disorder/Blood Clots:_____ YES
◯Yes ◯NO	Asthma/Breathing Disorders
◯YES ◯NO	Stomach ulcers
◯YES ◯NO	Chemical dependency (alcohol or drug)
◯YES ◯NO	Thyroid problems
◯YES ◯NO	Epilepsy/seizures
◯YES ◯NO	Diabetes
◯YES ◯NO	Multiple sclerosis/Neurological Conditions:_____
◯YES ◯NO	Rheumatoid arthritis/Other arthritic conditions:_____
◯YES ◯NO	Osteoporosis/Osteopenia
◯YES ◯NO	Hepatitis/Tuberculosis:_____
◯YES ◯NO	Kidney disease. If YES, what kind: _____
◯YES ◯NO	Visual Disorders (do you wear glasses):_____
◯YES ◯NO	Hearing Disorders
◯YES ◯NO	Known Allergies (ex: Latex, peanuts, medications)_____
◯YES ◯NO	Are you currently pregnant?
◯YES ◯NO	Have you had complicated pregnancies, abnormal menstrual cycle, pelvic inflammatory disease?
◯YES ◯NO	Have you experienced any recent unexplained weight changes (loss or gain)?
◯YES ◯NO	Have you had experienced any recent night sweats, pain or fever/chills?

List any medications or oral supplements that you are currently taking:

BU Physical Therapy Center

Please check the best response to the right of each statement.

I feel tired and unrefreshed when I wake from sleeping.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
My muscles feel stiff and achy	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have anxiety attacks	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I grind or clench my teeth.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have problems with diarrhea and/or constipation	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I need help in performing my daily activities.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I am sensitive to bright lights.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I get tired very easily when I am physically active	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I feel pain all over my body	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have headaches	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I feel discomfort in my bladder and/or burning when I urinate	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I do not sleep well	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have difficulty concentrating	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have skin problems such as dryness, itchiness, or rashes	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
Stress makes my physical symptoms worse	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I feel sad or depressed	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have low energy	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have muscle tension in my neck and shoulders	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have pain in my jaw	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
Certain smells, such as perfumes, make me feel dizzy and nauseated	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have to urinate frequently	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
My legs feel uncomfortable and restless when I am trying to go to sleep at night	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have difficulty remembering things	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have suffered trauma as a child	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
I have pain in my pelvic area	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐

Typing your full name below constitutes your legal signature

Patient Signature_____ Date_____

Therapist Signature_____ Date_____

BU Physical Therapy Center

Consent to Treatment

I understand that I have been referred for rehabilitative treatment to Boston University Physical Therapy Center and that the clinician, in conjunction with my referring physician, will prescribe an individual treatment program based on my diagnosis and goals. I understand that I have the right to have any questions regarding my treatment answered by the clinician and have the right to refuse care. I may also refuse care if provided by an affiliating student.

Payment Policy

- We will bill Medical, Worker's Compensation, and/or Automobile Insurance for your physical therapy visits.
- We aim for transparency and communication regarding the cost of your physical therapy care. Please see and ask for your benefit quote for specific information regarding your insurance benefits.
- You must provide us with complete details regarding your insurance information including the name of insurer, member id and/or claim number, and of any insurance changes during your care. **If this information is not complete, you will be responsible for the cost of the visit.**
- All copayments must be made **at the time of visit**. All deductible and coinsurance balances must be paid at the visit after they are processed by your insurance company.
- After treatment is completed, account balances are due within 30 days of final claims processing.
- We are sensitive to the financial needs our patients. Please communicate with clinical and administrative staff if cost is a barrier to your care. We will work with you to create a feasible payment arrangement.
- If you disagree with the way in which your insurance company has processed your claims, we ask that you contact them directly. We are happy to answer any other questions you have.

Consent to Payment Policy

FURTHERMORE, I authorize all insurance payments to be released to Boston University Physical Center for services rendered and understand that any outstanding balance is my responsibility.

Cancellation Policy

Out of mutual respect for the time of our physical therapists, your time, and that of all of our patients, we ask that you provide us with **at least 24 hour notice** of appointment cancellations. After **3** no showed or cancelled without 24 hour notice visits, **we reserve the right to bill $20.00 for any additional missed appointments.**

Typing your full name below constitutes your legal signature

Signature:_____ **Date**:_____

(Parent or Guardian must sign if patient is under the age of 18 or a fax copy of the signature is acceptable.)

BU Physical Therapy Center

Name: _____ Date: _____

The Modified Keele STarT Back Screening Tool

Thinking about the **last 2 weeks,** mark your response to the following questions.

		Disagree 0	**Agree** 1
1	My current pain has **spread to other body regions** at some time in the last 2 weeks.	☐	☐
2	I have had pain in **other body regions** other than my primary current pain.	☐	☐
3	I have only **walked short distances** because of my current pain.	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of my current pain.	☐	☐
5	I can't do all the things normal people do because it's too easy for me to get injured.	☐	☐
6	**I worry too much** over something that really doesn't matter.	☐	☐
7	**It's terrible,** and I think **it's never going to get any better**.	☐	☐
8	**Little interest or pleasure** in doing things.	☐	☐

9. Overall, how **bothersome** has your current pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

Funded by Arthritis Research UK

BU Physical Therapy Center

Name: _____

Patient Preference on Communications

The BU Physical Therapy Center uses email and text communication for various items including, but not limited to, appointment reminders and satisfaction surveys. Furthermore, many of our patients like the option of communicating by email with their therapists. It is important for you to understand that regular email and text are convenient but are generally not encrypted, and protected health information is therefore at risk of being intercepted. BU uses an encrypted email program to communicate securely, but it is less convenient as it requires you to log in to a separate site to obtain each message. We give you the choice below of regular email, secured email, or non-secure text.

If you choose the more convenient non-secure email or text, please note you are taking on the risk of interception, and you release Boston University and BU Rehabilitation Services from any liability for following your stated preference. If you contact us by non-secure email or text, we will assume you have made that choice.

Step One – Email Communication Preference

Please provide your communication preference below (choose **one** option):

☐ 1. Please use regular (non-secured) email to the following address: _____

☐ 2. Please communicate with me using DataMotion
Secure web-based email to the following address: _____

Step Two– Appointment Reminders *(*can only be sent via non-secure email or non-secure text)*:

Please authorize your preference below for appointment reminders:

☐ By email to the address listed in option 1 above.

☐ Text message to this cell phone number: _____

For text reminders, please indicate your Cell Phone Carrier:_____

This communication preference will remain in effect until you notify us you wish to change it.

Medication List

Please complete ONLY if you are insured by Medicare.

Medication Name	**Dosage**	**Frequency taken**	**Route of Administration (how do you take it?)**

BU Physical Therapy Center

Notice of Patient Rights

General Laws of Massachusetts (Massachusetts Outpatient Satellites) Chapter 111:
Section 70E. Patients' Bill of Rights.

Every patient shall have the right:

1. Upon request, to obtain from the facility in charge of his care the name and specialty, if any, of the physician or other person responsible for his care or the coordination of her/his care;
2. To confidentiality of all records and communications to the extent provided by the law;
3. To have all reasonable requests responded to promptly and adequately within the capacity of the facility;
4. Upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or education institution in so far as said relationship relates to his care or treatment;
5. To obtain for a person designated by the facility a copy of any rules or regulations of the facility which apply to his conduct as a patient or resident;
6. Upon request, to receive from a person designated by the facility any information which the facility has available relative to financial assistance and free health care;
7. Upon request, to inspect his medical records and to receive a copy thereof in accordance with section seventy, and the fee for said copy shall be determined by the rate of copying expenses, except that no fee shall be charged to any applicant, beneficiary or individual representing said applicant or beneficiary for furnishing a medical record if the record is requested for the purpose of supporting a claim or appeal under any provision of the Social Security Act or federal or state financial needs-based benefit program, and the facility shall furnish a medical record requested pursuant to a claim or appeal under any provision of the Social Security Act or any federal or state financial needsbased benefit program within thirty days of the request; provided, however, that any person for whom no fee shall be charged shall present reasonable documentation at the time of such records request that the purpose of said request is to support a claim or appeal under any provision or the Social Security Act or any federal or state financial needs-based benefit program;
8. To refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological, or other medical care and attention;
9. To refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;
10. To privacy during medical treatment or other rendering of care within the capacity of the facility;
11. To prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment unless such delay can be imposed without material risk to his health, and this right shall also extend to those persons not already patients or residents of a facility if said facility has a certified emergency care unit;
12. To informed consent to the extent provided by law;
13. Upon request to receive a copy of an itemized bill or other statement of charges submitted to any third party by the facility for care of the patient or resident and to have a copy of said itemized bill or statement sent to the attending physician of the patient or resident; and
14. If refused treatment because of economic status or the lack of a source of payment, to prompt and safe transfer to a facility which agrees to receive and treat such patient. Said facility refusing to treat such patient shall be responsible for: ascertaining that the patient by may be safely transferred; contacting a facility willing to treat such patient; arranging the transportation; accompanying the patient with necessary and appropriate professional staff to assist in the safety and comfort of the transfer, assure that the receiving facility assumes the necessary care promptly, and provide pertinent medical information about the patient's condition; and maintaining records of the foregoing.

15. To appropriate assessment and management of pain.

Continue reading on the next page

16. Upon request, to obtain an explanation as to the relationship, if any, of the physician to any other health care facility or educational institution in so far as said relationship relates to his care or treatment, and such explanation shall include said physician's ownership or financial interest, if any, in the facility or other health care facilities in so far as said ownership relates to the care or treatment of said patient or resident;
17. Upon request to receive an itemized bill including third party reimbursements paid toward said bill, regardless of the sources of payment;
18. In the case of a patient suffering from any form of breast cancer, to complete information on alternative treatment which are medically viable.
19. Except in cases of emergency surgery, at least ten days before a physician operates on a patient to insert a breast implant, the physician shall inform the patient of the disadvantages and risks associated with breast implantation.
    The information shall include, but not be limited to, the standardized written summary provided by the department. The patient shall sign a statement provided by the department acknowledging the receipt of said standardized written summary. Nothing herein shall be construed as causing any liability of the department due to any action or omission by said department relative to the information provided pursuant to this paragraph.
20. Every maternity patient, at the time of pre-admission, shall receive complete information from an admitting hospital on its annual rate of primary caesarian sections, annual rate of repeat caesarian section, annual rate of total caesarian sections, annual percentage of women who have had a caesarian section who have had a subsequent successful vaginal birth, annual percentage of deliveries in birthing rooms labor-delivery-recovery-postpartum rooms, annual percentage of deliveries by certified nurse-midwives, annual percentage which are continuously externally monitored only, annual percentage which were continuously internally monitored only, annual percentage which were monitored both internally and externally, annual percentage utilizing intravenous, inductions, augmentations, forceps, episiotomies, spinals, epidurals and general anesthesia, and its annual percentage of women breast-feeing upon discharge from said hospital.
21. A facility shall require all persons including students, who examine, observe or treat a patient or resident of such facility to wear an identification badge which readily discloses the first name, licensure status, if any, and staff position of the person so examining, observing or treating a patient or resident.
22. Any person whose rights under this section are violated may bring, in addition to any other action allowed by law or regulation, a civil action under sections sixty B to sixty E, inclusive, of chapter two hundred and thirty-one. Any person may file a complaint with the Massachusetts Department of Health Care Quality, 617-753-8000 or 800-4625542
23. No provision of this section relating to confidentiality of records shall be construed to prevent any third party reimburse from inspecting and copying, in the ordinary course of determining eligibility for or entitlement to benefits, any and all records relating to diagnosis, treatment, or other services provided to any person, including a minor or incompetent, for which coverage, benefit or reimbursement is claimed, so long as the policy or certificate under which the claim is made provides that such access to such records is permitted. No provision of this section relating to confidentiality of records shall be construed to prevent access to any such records in connection with any peer review or utilization review procedures applied and implemented in good faith.
24. No provision herein shall apply to any institution operated by and for persons who rely exclusively upon treatment by spiritual means through prayer for healing, in accordance with the creed or tenets of a church or religious denomination, or patients whose religious beliefs limit the forms and qualities of treatment to which they may submit.
25. No provision herein shall be construed as limiting any other right or remedies previously existing at law.

I certify I have reviewed the Patients' Bill of Rights

Typing your full name below constitutes your legal signature

_____ _____

Signature Date

Notice of Privacy Practices

Effective April 10, 2017

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. OUR RECORD OF YOUR HEALTH INFORMATION

Each time you receive services, a record of your visit is made. This record may describe your condition, diagnoses, treatments and/or a plan for future care. Health information such as test results, medications and information obtained by your provider will be recorded.

2. WHEN WE NEED YOUR WRITTEN PERMISSION TO USE AND DISCLOSE YOUR HEALTH INFORMATION

We must obtain your written authorization for uses and disclosures of your health information, except as described below in this Notice.

We must, for example, obtain your written authorization for certain uses and disclosures involving the sale of your health information or for any use or disclosure of your health information for marketing purposes.

3. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS WITHOUT YOUR WRITTEN AUTHORIZATION

We may use or disclose your health information without your written authorization for the purposes of treatment, payment and health care operations. Examples of such uses are as follows:

Treatment – to provide, manage and coordinate your health care. Your treatment could also involve disclosing information to other providers such as a referring health care provider or other health care providers involved in your care for the purpose of providing you excellent, coordinated care; sending you appointment reminders; contacting you about your care and treatment choices, or telling you about services that may interest you.

Payment – to obtain payment and determine health insurance eligibility. We may tell your health plan about treatment or services that may require its prior approval.

Health Care Operations – to assess the quality of care we provide, to improve our services, to train our staff and students, and to manage our operations and services. We may also use your health information without your written authorization to contact you for fundraising, but you have the right to opt out of receiving such communications.

4. WE MAY BE PERMITTED OR REQUIRED TO USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

We are also permitted or required to use your health information or disclose your health information to others without your written authorization as follows:

- To avert a serious threat to health or safety to you or to others.
- Within BU Rehabilitation Services and to business associates as needed for assistance with our operations, subject to protections for your health information.
- For research preparation and research that has been granted a HIPAA waiver of authorization from the Institutional Review Board.
- Incidental to a use or disclosure otherwise permitted or required.
- If we are required by law to disclose your health information, such as when we have reason to suspect abuse or neglect of children, elders or disabled persons.
- For public health activities, such as reporting infectious diseases to boards of health, births or deaths or reactions to vaccines or medical devices to the FDA.
- For federal and state health oversight activities such as fraud investigations.
- As authorized by and necessary to comply with workers' compensation law or similar programs if you are injured or become ill at work.
- In judicial or administrative proceedings, pursuant to, for example, a subpoena, court order, or other lawful process.
- To coroners, medical examiners and funeral directors.
- To organ, eye or tissue donation programs involving decedents.

Continue reading on the next page

- To law enforcement officials in limited circumstances.
- To the Secretary of Health and Human Services, if it conducts an investigation to determine our compliance with HIPAA.
- For specialized government functions such as national security or intelligence inquiries.
- To a correctional institution if you are an inmate.
- Unless you object, to family and friends involved in your care if, in our professional judgment, it is in your interest for us to disclose information directly relevant to that person's involvement with your care.
- Unless you object, to a family member, personal representative, or person responsible for your care in order to notify them of your location, general condition, or death.
- Unless you object, to public or private entities for disaster relief efforts.
- Otherwise, as required or permitted by HIPAA and all other applicable laws.

We are also subject to state and federal laws that give special protection to certain types of health information, and we will comply with these laws if applicable. These laws relate to:

- HIV/AIDS testing or test results,
- Genetic testing and test results,
- Information about sexually transmitted diseases,
- Substance abuse and rehabilitation treatment information, and
- Sensitive information such as sexual assault counseling records or communications between you and a social worker, psychologist, psychiatrist, psychotherapist or licensed mental health nurse clinical specialist.

5. YOUR RIGHT TO INSPECT AND RECEIVE COPIES OF YOUR HEALTH INFORMATION AND TO REQUEST THAT WE RELEASE YOUR HEALTH INFORMATION TO OTHERS.

You have the right to inspect and receive copies of your health information in our health records and to request that we release a copy of this health information to others. A modest fee may be charged. Please speak to your clinician if you have questions about making a request. Your request may be denied in whole or in part when the following circumstances exist:

- Information compiled in anticipation of or use in a civil, criminal or administrative action or proceeding.
- Health information created or obtained in the course of research, while the research is in progress.
- Health information that we obtained from someone other than a health care provider under a promise of confidentiality if the access requested would be reasonably likely to reveal the source of the information.
- Health information that is reasonably likely to endanger the life or physical safety of you or another person.
- Health information by your personal representative if in our judgment such access is reasonably likely to cause substantial harm to you or another person.

We retain our health records for 20 years from the date of final treatment.

6. YOUR ADDITIONAL RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Receive a copy of their Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your health record.
- Request, in writing, that we restrict how we use or disclose your health information. For example, you may request us not to disclose health information to a health plan for payment pertaining to items or services for which we have been paid in full by you or a person other than the health plan.
- Revoke, in writing, any authorization you have given to disclose your information; but we won't be able to take back information we have already disclosed.
- Request a confidential and/or alternate modes of communication.
- Request in writing an amendment to the information in your health record.
- Request in writing and receive an accounting of the disclosures we have made of your health information, except for disclosures to you, disclosures you authorized, and disclosures that are permitted or required without your authorization.
- Make a complaint about our privacy practices.
- In the event of a breach of your unsecured protected health information, to receive notification of the breach.

Continue reading on the next page

7. OUR RESPONSIBILITIES

We are required by law to:

- Maintain the privacy of your health information.
- Provide you this Notice of your rights and our duties and our privacy practices.
- Abide by the terms of our Notice of Privacy Practices as currently in effect.
- Notify you following a breach of your unsecured protected health information.
- Notify you if we are unable to continue to comply with your restriction request.

We reserve the right to change our privacy practices and this Notice and to make the new practices effective for all your health information including information we already have about you. The revised Notice will be posted on our website and made available at our treatment site.

8. TO EXERCISE YOUR RIGHTS OR FILE A COMPLAINT

If you have questions about this Notice, would like to exercise your rights, or wish to file a formal complaint regarding the privacy of your health information please contact:

BU HIPAA Privacy Officer, at 617-358-3124 or via electronic mail to HIPAA@BU.EDU.

If you believe your privacy rights have been violated, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The mailing address is:

Centralized Case Management Operations, U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg.

Washington, D.C. 20201

You will not be penalized or subject to retaliation for filing a complaint.

End of Privacy Practices Policy
Please Sign the next page

Acknowledgement That Notice Of Privacy Practices Was Given

PATIENT

PRINT Full Name _____ Date of Birth _____

I was given a copy of the Notice of Privacy Practices that describes how my information is used and disclosed.

**Typing your full name below constitutes your legal signature*

_____ _____

Signature of individual or representative **(if representative, relation to patient)** **Date**

ADMINISTRATIVE USE ONLY

If patient declines to sign, staff should document below:
I provided the Notice of Privacy Practices to the patient or his/her Legally Authorized Representative on this date.

_____ _____ _____

Signature of BURS Staff **Title** **Date**

Place completed form in Individual's Medical Record.