Little Shell Healthcare Program
A "NEW" PATIENT APPOINTMENT

GENERAL ELIGIBLITY REQUIREMENTS: MUST BE an enrolled member or Descendent of an enrolled member of a Federally Recognized Tribe.

INFORM PATIENT TO CHECK IN AT LEAST 1 HOUR PRIOR TO APPOINTMENT IN ORDER TO ESTABLISH CHART WITH ALL DOCUMENTS

a. PROOF of being a member or descendent of Tribal member. MUST BRING YOUR TRIBAL ID/CIB to your 1st appointment to establish eligibility.

b. IF DESCENDENT of parent, grandparent, we will need their TRIBAL ID & STATE BIRTH CERTIFICATES for ALL FAMILY MEMBERS WHICH links the patient to the Tribal Member to show proof of Decendency.

- **Example**: Patient is descendant of Grandmother; we will need Grandmothers Tribal ID, Parent State Birth Certificate and Patient's State BC; all birth certificates showing names or lineage "link" back to Grandmother.

c. ADDITIONAL DOCUMENTS we will also need:
- **Social Security Card** - our system is linked to Social Security Administration and once we put in the RPMS/GUI system it takes time for SSA to verify. That is why you see on page 2 in RPMS (Verified by SSA OR Not Verified by SSA).
- **State ID Card or Driver's License** (picture ID)
- **Insurance Cards**. (So proper ID/Group Name/Group # is entered for billing purposes).
- **Military DD-214** for those that served in the U.S. Military. Veterans maybe eligible for Veterans Medical Beneficiary.

d. CUSTODY/GUARDIAN PAPERWORK for Minors.

e. PARENTAL PRE-AUTHORIZATIONS signed by parent/legal guardian if you want another person to bring your child or children to a doctor's appointment. You can fill out the proper I.H.S. forms at patient registration.

f. NEWBORN: We will need Mothers Tribal ID along with the Hospital Record and/or CRIB Card at first visit; mothers name will be on the Hospital Record of Birth/CRIB Card. **WE WILL NEED STATE BIRTH CERTIFICATE ONCE PARENT RECEIVES IT WITH IN 60 DAYS OR patient will be considered ineligible.**

Eligibility will be extended to NON-INDIAN in only three (3) situations:

a. Non-Indian woman pregnant with eligible Indian's child for duration of pregnancy through six (6) weeks post-partum for pregnancy related care only. WE WILL NEED PROOF OF PREGNANCY FROM OUTSIDE FACILITY BEFORE APPOINTMENT.

b. Non-Indian member of eligible Indian's household-public health hazard only.

c. Non-Indian: adopted, foster, step-child/children of eligible Indian until age of 19 years of age. (PL100-713). **NOTE:** Non-Indian patients who do not meet the above eligibility **but present at I.H.S. Emergency Room** for emergency care (prevent immediate death, serious impairment to life, limb, senses) can be treated, stabilized and outed to a NON-I.H.S. facility with patient responsible for costs; they will need to follow up with their own provider.

PATIENT REGISTRATION

HRN:_____

Name:_____ DOB:_____
First Middle Last

Birthplace:_____ SS#:_____ Male:___ Female:___
City/State

Marital Status: Single___ Married___ Widow/Widower___ Divorced___ Separated___

Mailing Address:_____
Street Address/P.O. Box City State Zip

Location of Home:_____
If Different from Above

Home Phone:_____ Cell #:_____ Work #:_____ Message #:_____

E-mail Address:_____ Religious Preference:_____

TRIBAL INFORMATION: You Must Provide Proof of Enrollment/Descendancy to a Federally Recognized Tribe.

Tribe of Membership:_____ Enrolled/Descendant (circle one)

Tribe Quantum:_____ Indian Blood Quantum:_____ Enrollment #:_____

Father's Name:_____ Birthplace:_____
First Last City/State

Mother's Maiden Name:_____ Birthplace:_____
First Last City/State

Father's Phone #:_____ Mother's Phone #:_____

Father's Employer:_____ Mother's Employer:_____

Father's E-mail Address:_____ Mother's E-mail Address:_____

Employer Name:_____

Employer Address & Phone:_____

Spouse's Employer Name:_____

Spouse's Employer Address:_____ Employer Phone:_____

Emergency Contact:_____ EC Phone:_____

Emergency Contact Address:_____ Relationship to EC:_____
City/State/Zip

Next of Kin:_____ NOK Phone:_____

NOK Address:_____ Relationship to NOK:_____
City/State/Zip

Insurance Information (Check All that Apply): **Medicaid:___** **Medicare:___** **Railroad:___**

*****Please present Insurance Card & complete the reverse side of form***** **Private Insurance:___** **Other:___** **None:___**

Are You a Veteran? Yes___ No___ If you answered Yes, what Branch?_____

Entry Date:_____ Separation Date:_____ Vietnam Service Indicated? Yes___ No___

Service Connected? Yes___ No___ Valid VA Card? Yes___ No___

Description of VA Disability:_____

Please Read the Following Before Signing Below:

Privacy Act of 1974, Public Law 93-579: I understand that the Information given by me and/or collected is necessary for the Indian Health Service to provide services for my health care and well being. Furthermore, I have been informed that my record shall not be disclosed to any other agency or person without my signed consent. I certify the above information is correct to the best of my knowledge.

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN (if patient is a minor) **DATE**

Ethnicity: Are you Hispanic or Latino? Yes_____ No_____

Primary Language Spoken:_____

Other Language Spoken:_____ Preferred Language:_____

Are You a Migrant Worker? Yes_____ No____ Are You Homeless? Yes____ No____

Complete the following if you have Private Insurance, Workman's Comp, or Motor Vehicle Accident Insurance

Name of Insurance Company:_____

Address of Insurance Company:_____

Phone # of Insurance Company:_____ Policy/Claim #:_____

Policy Effective Date:_____ Policy Term Date:_____

Name of Policy Holder:_____

Policy Holder Date of Birth:_____ SS#:_____

Policy Holder Employer Name:_____

Employer Address:_____ Phone #:_____

Other Policy Members	Relationship to Policyholder	Date of Birth

MEDICARE ONLY: Please present your card and complete the following:

Name:_____ Medicare #:_____
(As Shown on Card)

Part A: Yes___ No___ Effective Date:_____ Part B: Yes___ No___ Effective Date:_____

Medicare D (Prescription Drug Coverage): Yes___ No___ Plan Name:_____

If you have Insurance:

The Indian Health Service may disclose information from my medical record to the Insurance Corporation, which is or may be liable for all or part of the medical services and supplies provided by the Indian Health Service. I hereby assign the Indian Health Service such insurance benefits that I may have pertaining to payment for medical services and supplies furnished by Indian Health Service. I authorize such benefits directly to the Indian Health Service.

STATE OF PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER:

I request that the payment of authorized Medicare benefits be made on my behalf to Indian Health Service Clinic/Hospital for any services furnished to me by this facility and attending physicians. I have also authorized any holder of needed medical information, pertaining to me, be released to the Montana Medical Foundation for Medical Care and its agents, to determine these benefits or the benefits payable to related services. This authorization shall cover inpatient and outpatient visits, clinic, and/or hospital.

_____ _____

POLICY HOLDER'S SIGNATURE DATE

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service
PHS Indian Health Center
Great Falls, Montana 59404

LITTLE SHELL SERVICE UNIT SERVICE AGREEMENT – AMBULATORY HEALTH CENTER

1. AUTHORIZATION FOR AMBULATORY CARE AND/OR TREATMENT: I voluntarily agree and consent to treatment and services that my provider deems necessary.
2. RELEASE OF INFORMATION FOR BILLING SERVICE AND REVIEW: I understand that Little Shell Service Unit (LSSU) may disclose all or any reasonable part of my record to include information pertaining to medical history, mental or physical conditions, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the clinic's charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit or any purposes reasonable related to these activities. I understand that this authorization will remain in effect for the long-term period ambulatory services, unless revoked in writing prior to that date.
3. MEDICAL IMAGES: I understand that photographs, videotapes, digital or other images (medical images) may be recorded to document my care and treatment I consent to this. I understand that LSSU will retain ownership rights to these medical images, but that I will be allowed access to view them or obtain copies. I understand that these medical images will be stored in a secure manner that will protect my privacy. Images will be released or used outside LSSU only upon written authorization from my legal representative or me.
4. ASSIGNMENT OF INSURANCE BENEFITS-PRIVATE HEALTH INSURANCE: I hereby authorize payment directly to the Little Shell Service Unit, of the care benefits otherwise payable to me but not to exceed the regular charges for this period of service. Authorization is not limited to private health insurance but may include others sources such as Medicare and Medicaid, and/or reimbursable insurance for any services I receive.
5. MEDICAID: I understand that I may be asked to present my current identification card each time I receive services. I understand that I am required to submit an application for Medicaid if referred by a Physician, Benefit Coordinators or other provider.
6. MEDICARE: By signing this agreement, I have given Little Shell Service Unit a "Statement of Permit for Payment of Medicare benefits to this Provider." It is my understanding that the Professional Review Organization and its agents may receive information needed to determine benefits payable.
7. NON-BENEFICIARY FINANCIAL AGREEMENT: I understand and agree with the following: That in consideration for the services rendered to me, I am responsible to pay the bill of the services received in accordance with the regular rates and terms of LSSU. Any cost denied by an insurance agent or other responsible party, including co-payments and deductions will be my responsibility.
    - Medicaid: I understand that if I do not identify myself as a Medicaid recipient, I will be responsible for this bill. Services not paid or covered under the Medicaid program will be billed to me.
    - Medicare: You are expected to pay the Medicare deductible coinsurance. If for some reason the services received does not meet the requirement of my insurance agency, I will be responsible for the entire bill.
8. PATIENT RIGHTS AND RESPONSIBILTIES: I have read and understand the Patient Rights and Responsibilities document given to me.
9. ADVANCED DIRECTIVES: I have been informed and fully understand the options for advanced directives.
10. GRIEVANCE: I have been informed and fully understand the process for grievance concerns.
11. AGREEMENT: My signature indicates that, I agree and understand the contents of the service agreement, my rights and responsibilities as a patient, and that I have received a copy of the documents.

Signed by Patient/Legal Representative_____ Date_____/_____/_____

CHART NO: _____ DOB: _____/_____/_____ Time: _____

Revised 4/2022 TJP

INTERVIEWED AND INFORMATION UPDATED BY: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Services Hospital
Little Shell Service Unit
Great Falls, Mt 59404

PATIENT: _____ CHART: _____

BASIS FOR ENTITLEMENT TO MEDICARE: ___ AGE ___DISABILITY
___ END STAGE RENAL DISEASE

ARE YOU CURRENTLY EMPLOYED? _____ YES _____ NO

IS THIS ILLNESS/INJURY DUE TO AN ACCIDENT (AUTO)? _____ YES _____ NO

IS THE VISIT PAYABLE TO WORKERS COMPENSATION INSURANCE? _____YES _____ NO

DO YOU HAVE A VA FEE SERVICE CARD? _____ YES _____NO

DO YOU HAVE BLACK LUNG DISEASE? _____YES _____NO

PATIENT SIGNATURE: _____ DATE: _____

PATIENT UNABLE TO SIGN (REASON): _____

_____

(EXAMPLES: NURSING HOME PATIENT, MEDICAL CONDITION, OR INJURY)

EMPLOYEES SIGNATURE: _____ DATE: _____

IHS-976 (10/2017)

DEPARTMENT OF HEALTH AND HUMAN SERVICE
Indian Health Service

FORM APPROVED: OMB NO. 0917-0040
Expiration Date: 03/31/2022
See OMB Statement on Page 3

PURCHASED / REFERRED CARE
PROOF OF RESIDENCY

The Indian Health Service (IHS) provides services through Purchased/Referred Care (PRC) to American Indian/Alaska Native people who live within the designated geographic area known as a PRC delivery area. The PRC program is authorized to pay for medical care provided to IHS beneficiaries by non-IHS or Tribal, public or private health care providers, depending on the availability of funds.

Federal law generally requires residency within the PRC delivery area in order to receive services through PRC. If you are requesting PRC authorization of payment by the IHS for medical services/treatment from a non-IHS provider, you must prove that you reside within the PRC delivery area.

Please print when completing this form. If you need help in completing the sections, you may ask for assistance and instructions from the IHS PRC Office.

Section A: Your Information (Required)			
Last Name	First Name	Middle Initial	Date of Birth
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?		
Home street address:	Post Office Box:	Home phone number:	
City:	State:	Zip Code:	Cell phone number:
Physical location: *(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)*			
Have you lived at this location for more than six months? ☐ Yes ☐ No	If not, provide your old address.		
Are you homeless? ☐ Yes ☐ No	Contact phone number:		

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to beneficiaries of the IHS who live in the PRC delivery area.

_____ _____

Applicant Signature Date

Provide one of the following to show that you live within the PRC delivery area.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing address and withholding taxes.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
Valid college ID with a photo	Property Deed	Marriage License
Other Tribal government issued documents.		

If you do not have any of these documents, you can prove that you live in the PRC delivery area by completing Section B **or** Section C.

Another resident of the PRC delivery area, who knows where you live, can verify your residency by filling out Section B. If you do not know anyone who is willing or able to verify where you live, a local non-profit social services provider can verify your residency by completing Section C.

Section B: Individual Verifier's Information

This section must be filled out by a resident who knows where you, the applicant, live – someone you live with is best. If you do not know anyone who is willing or able to verify where you live, a local non-profit organization that provides you with services may complete Section C for you. *(You do not need to fill in Section C if this section is completed.)*

Last Name:	First Name:	Middle Initial

Home address:	Post Office Box:	Home phone number:

City:	State:	Zip Code:	Cell phone number:

Physical location: *(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)*

How do you know the applicant?

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to people who live in the PRC delivery area.

By signing below, I verify that, to the best of my knowledge, the applicant listed in Section A on page 1 lives at the location stated in Section A.

_____ _____

Verifier's Signature Date

The individual verifier must sign Section B and provide a copy of at least one (1) of the following documents showing the **verifier's** name and address.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing name and address.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
Valid U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
	Property Deed	

Section C: Organizational Verifier's Information

This section must be filled out by a local non-profit organization, social services, or other services organization that serves you, the applicant. *(You do not need to fill in Section B if this section is completed.)*

Organization Name:	Organization Tax Exempt ID Number:	
Verifier's Name:	Verifier's Title:	
Telephone number:	Email address:	
Organization Address:		
City:	State:	Zip Code:

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to people who live in the PRC delivery area.

By signing below, I verify that, to the best of my knowledge, the applicant listed in Section A on page 1 lives at the location stated in Section A.

_____ _____

Verifier's Signature Date

Reminder to the Applicant:

Before you turn in this application, make sure it is complete. **In order to be completed, you must have:**

- Section A filled out with documentation; **OR**
- Section A filled out with no documentation **AND** completed Section B or Section C.
- If you use Section B, you must have a copy of the individual verifier's proof of residency documentation.

Privacy Act Notice

The Privacy Act of 1974 (5 U.S.C. § 552a (e) (3) requires that the following notice be provided to you. The information requested on the Purchase/Referred Care (PRC) Proof of Residency form is collected to determine eligibility for and administration of PRC benefits under the Snyder Act (25 U.S.C. § 13), the Transfer Act of 1954 and implementing regulations at 42 C.F.R. Part 136. Purposes and uses – the information requested is collected for the purposes of reviewing eligibility for PRC services. The information provided on this form will be maintained in the applicant's medical record. The information will not be disclosed to entities outside the Indian Health Service (IHS) without prior written permission except for routine uses identified in the IHS System of Records 09-17- 0001 Medical, Health and Billing Records. Effects of nondisclosure – the information is required in order to determine eligibility for the receipt of PRC services.

OMB Burden Statement

Public reporting burden for this collection of information is estimated to average 3 minutes per response including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, Office of Management Services, Division of Regulatory Affairs, 5600 Fishers Lane, Mail Stop 09E70, Rockville MD 20857, RE: OMB No. 0917-0040. Please DO NOT SEND this form to this address.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

ACKNOWLEDGEMENT OF RECEIPT OF IHS NOTICE OF PRIVACY PRACTICES

Form Approved:
OMB No. 0917-0030
Expiration Date:
December 31, 2026
See OMB Statement Below

By signing this form, you acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your medical information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by logging onto https://www.ihs.gov/sites/hipaa/themes/responsive2017/display_objects/documents/NoticePrivacyPracticePamphlet.pdf or by contacting the IHS Privacy Officer at (240) 479-8521.

If you have any questions about our Notice of Privacy Practices, please contact the IHS Privacy Officer at (240) 479-8521.

NAME OF PATIENT

SIGNATURE OF PATIENT | DATE *(mm/dd/yyyy)*

IF PATIENT IS UNABLE TO SIGN:

NAME OF LEGAL REPRESENTATIVE AND STATE RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT REPRESENTATIVE | DATE *(mm/dd/yyyy)*

SIGNATURE AND TITLE OF CSU STAFF | DATE *(mm/dd/yyyy)*

STAFF ONLY: FOR PATIENTS UNABLE TO ACKNOWLEDGE RECEIPT

I hereby certify that the patient was unable to acknowledge receipt of the IHS Notice of Practices because:

SIGNATURE OF IHS STAFF | DATE *(mm/dd/yyyy)*

IHS STAFF USE ONLY:

HEALTH RECORD NUMBER | D.O.B. *(mm/dd/yyyy)*

OMB STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

Nam... ...st, M.I.):_____ ☐ M ☐ F **DOB:**____/____/____

HEALTH HISTORY QUESTIONNAIRE

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children: _____ **How many live with you?** _____ **Occupation is/was:** _____

Previous or referring doctor:_____ **Date of last physical exam:** _____

HEALTH HISTORY

Tests/Screenings and Dates: ☐ Eye Exam_____ ☐ Colonoscopy_____ ☐ Dexa Scan_____

Hospitalizations /or Surgeries

Year_____ Reason_____ Hospital _____

Year_____ Reason_____ Hospital _____

Year_____ Reason_____ Hospital _____

Year_____ Reason_____ Hospital _____

☐ I have had no surgeries ☐ I have never been hospitalized

Have you ever had a blood transfusion? ☐ Y ☐ N

Please list other physicians you have seen in the last 12 months, and for what reason.

_____

_____

Name (Last, First, M.I.):_____DOB ____/____/_____

YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Growth/Development Disorder
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Pain/Angina
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ H IV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other Disease, Cancer, or Significant Medical Illness

☐ NONE of the Above

List other past medical problems:_____

List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers

Med_____ Dose/Frequency_____

Med_____ Dose/Frequency _____

Med_____ Dose/Frequency_____

Med_____ Dose/Frequency _____

Med_____ Dose/Frequency_____

Med_____ Dose/Frequency _____

☐ List additional drugs on back of questionnaire ☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

Allergies

Name_____ Reaction you had _____

Name_____ Reaction you had _____

Name_____ Reaction you had _____

Name_____ Reaction you had _____

☐ I have no known **drug** allergies

Name (Last, First, M.I.):_____DOB ____/____/_____

FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: *(**ONLY** include parents, grandparents, siblings, and children)*

☐ I am adopted and do not know biological family history ☐ Family History Unknown

☐ Mother, Grandmother, or Sister developed heart disease before the age of 65

☐ Father, Grandfather, or Brother developed heart disease before the age of 55

Disease/Conditions	**Relationship to you** (mom, grandparents, siblings, and children)
☐ Seizures/Convulsions	_____
☐ Colon Cancer	_____
☐ Migraines	_____
☐ Osteoporosis	_____
☐ Alcohol Abuse	_____
☐ Depression	_____
☐ Lung/Respiratory Disease	_____
☐ Anemia	_____
☐ Diabetes	_____
☐ Breast Cancer	_____
☐ Anesthetic Complication	_____
☐ Heart Disease	_____
☐ Rectal Cancer	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ High Cholesterol	_____
☐ High Blood Pressure	_____
☐ Other Cancer	_____
☐ Bladder Problems	_____
☐ Kidney Disease	_____
☐ Stroke/CVA of the Brain	_____
☐ Bleeding Disease	_____
☐ Leukemia	_____
☐ Thyroid Disorder	_____
☐ Severe Allergy	_____

Name (Last, First, M.I.):_____DOB ____/____/_____

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise

Do you exercise? ☐ Y ☐ N

If yes, how many minutes per week?_____

Diet

Are you dieting? ☐ Y ☐ N If yes, are you on a physician prescribed medical diet? ☐ Y ☐ N

# of meals you eat in an average day?_____

Rank salt intake ☐ Hi ☐ Med ☐ Low

Rank fat intake ☐ Hi ☐ Med ☐ Low

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day?_____

Alcohol

Do you drink alcohol? ☐ Y ☐ N

If yes, what kind?_____ How many drinks per week?_____

Are you concerned about the amount you drink? ☐ Y ☐ N

Have you considered stopping? ☐ Y ☐ N

Have you ever experienced blackouts? ☐ Y ☐ N

Are you prone to "binge" drinking? ☐ Y ☐ N

Do you drive after drinking? ☐ Y ☐ N

Tobacco

Do you use tobacco? ☐ Y ☐ N

☐ Cigarettes – pks./day_____ **or** pks./week ____ ☐ Chew - #/day____ ☐ Pipe - #/day____ ☐ Cigars - #/day__ ☐ # of years__ ☐ Previous tobacco user - year quit _____

Drugs

Do you currently use recreational or street drugs? ☐ Y ☐ N

Have you ever given yourself street drugs with a needle? ☐ Y ☐ N

☐ I prefer to discuss with the physician

Sex

Are you sexually active? ☐ Y ☐ N

If yes, are you and your partner trying for a pregnancy? ☐ Y ☐ N

If not trying for a pregnancy list contraceptive or barrier method used:_____

Any discomfort with intercourse? ☐ Y ☐ N

Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse.

Would you like to speak with your provider about your risk of this illness? ☐ Y ☐ N

Name (Last, First, M.I.):_____DOB ____/____/_____

Personal Safety

Do you live alone? ☐ Y ☐ N

Do you have frequent falls? ☐ Y ☐ N

Do you have vision or hearing loss? ☐ Y ☐ N

Physical and/or mental abuse have also become major public health issues in this country.
This often takes the form of verbally threatening behavior or actual physical or sexual abuse.

Would you like to discuss this issue with your provider? ☐ Y ☐ N

How often do you have sun exposure? ☐ Occasionally ☐ Frequently ☐ Rarely

Have you ever experienced a sunburn? ☐ Y ☐ N

How often do you wear your seatbelt? ☐ Occasionally ☐ Frequently ☐ Always

These questions are for WOMEN ONLY

Age at onset of menstruation: _____ Date of last Menstruation: _____ Period every _____days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Y ☐ N

Number of pregnancies:_____ Number of live births:_____

Are you pregnant or breastfeeding? ☐ Y ☐ N

Have you had a D&C, hysterectomy, or Cesarean? ☐ Y ☐ N

Any urinary tract, bladder, or kidney infections within the last year? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Any problems with control of urination? ☐ Y ☐ N

Any hot flashes or sweating at night? ☐ Y ☐ N

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Y ☐ N

Do you perform monthly breast self exams? ☐ Y ☐ N

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Y ☐ N

Date of last pap smear or pelvic exam:_____

These questions are for MEN ONLY

Do you usually get up to urinate during the night? ☐ Y ☐ N

Do you feel pain or burning with urination? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Do you feel burning discharge from penis? ☐ Y ☐ N

Has the force of your urination decreased? ☐ Y ☐ N

Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Y ☐ N

Name (Last, First, M.I.):_____DOB ____/____/_____

Do you have any problems emptying your bladder completely? ☐ Y ☐ N

Any difficulty with erection or ejaculation? ☐ Y ☐ N

Any testicle pain or swelling? ☐ Y ☐ N

Date of last prostate and rectal exam:_____

Other Information Your healthcare provider needs to know:

Do you have Advanced Directives? *(Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive.* ☐ Y ☐ N

If no, would you like additional details about Advanced Directives? ☐ Y ☐ N

Do you have any religious or cultural beliefs that may impact your healthcare? ☐ Y ☐ N

If yes, please describe:_____

I best learn new information by: ☐ Verbal instructions ☐ Written instructions ☐ Pictures

Level of education completed: ☐ Less than High School ☐ High School diploma or GED ☐ 1-4 years of college ☐ > 4 years of college

I understand English well? ☐ Y ☐ N If no, what language do you prefer?_____

Patient's Signature:_____Date:_____

Reviewed By: _____ Date:_____

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Montana Provider Orders for Life-Sustaining Treatment (POLST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- Completing a POLST is **ALWAYS VOLUNTARY**.

Legal Last Name	
Legal First Name/Middle Name	
Date of Birth	

In preparing these orders, inquire if the patient has a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed.

A Check one box only

CARDIOPULMONARY RESUSCITATION (CPR) *****Person has NO pulse and is not breathing.*****

☐ **YES CPR:** Attempt Resuscitation ☐ **NO CPR:** Do Not Attempt Resuscitation (DNAR)/ Allow Natural Death (AND)

***NOTE:** Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B. When not in cardiopulmonary arrest, follow orders in Section B.*

B Check one box only

MEDICAL INTERVENTIONS *****Person HAS a pulse and is breathing.*****

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatments described below in "Selective Treatment" and "Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion, as indicated. Transfer to hospital, if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described below in "Comfort-focused Treatment," use IV antibiotics and IV fluids, as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route, as needed; use oxygen, suctioning, and manual treatment of airway obstruction, if indicated. Do not use treatments listed in "Full Treatment" and "Selective Treatment" above, unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

C Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION ** ***If feasible, always offer food & water by mouth.*** **

☐ Artificial nutrition by tube--long term/permanent, if indicated.
☐ Artificial nutrition by tube--short term/temporary only.
☐ No artificial nutrition by tube. ☐ No decision has been made

D

DISCUSSED WITH (check all that apply):
☐ Patient
☐ Medical Power of Attorney
☐ Legal guardian
☐ Other (Name & Relationship):_____

SIGNATURES OF PROVIDER AND PATIENT, Surrogate, Medical Power of Attorney, and Legal GUARDIAN (*MANDATORY*)

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate. Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Power of Attorney, CPR order, Living Will, or other Advance Directive (attach if available).

Patient/Legal Decision Maker Signature (Mandatory)	*Name (Print)*	*Relationship/ Decision maker status (Write "self" if patient)*	*Date Signed (Mandatory)*

SIGNATURE OF PROVIDER: **My signature below indicates to the best of my knowledge that these orders are consistent with the patient preferences.**

Name of Person Preparing Form	*Phone number of Preparer*	*Date Performed*

Physician / APRN / PA Signature (Mandatory)	*Print Physician / APRN / PA Name*	*Date Signed (Mandatory)*

Directions for Health Care Professionals

Completing POLST

- Completed by a health care professional based on patient preferences and medical indications.
- Provider signature must be a Montana licensed physician, advanced practice registered nurse or physician assistant.
- Patient (or legal decision-maker, if patient unable to make medical decisions), **must sign** to be valid.
- Verbal orders are acceptable with follow-up signature by provider in accordance with organization/ community policy.
- Documentation of conversations regarding POLST completion should be in the medical record.
- Use of the original form is strongly encouraged. Photocopies and FAXs of signed POLST forms are legal and valid. The patient should retain the original on "Terra" Green colored paper.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- **No** defibrillator (including automated external defibrillators) should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi- level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-focused Treatment," should be transferred to a setting able to provide comfort (i.e. treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort-focused Treatment."

Section C:

- Certain medical conditions may prevent intake of food and water, as it can worsen symptoms.
- If this applies, further discussion with and documentation by a healthcare provider is required.

Reviewing POLST

- Previously completed advance directives should not conflict with these Montana Provider Orders for Life-Sustaining Treatment (POLST) unless significant discussion and documentation between the patient, legal decision maker and healthcare provider occurs and is documented.
- POLST review is recommended when:
    - The patient is transferred from one care setting or care level to another.
    - There is substantial change in the patient's health care status including previous wishes that conflict with medical recommendations.
    - The patient has a change in treatment preference.

Modifying and Voiding POLST

- At any time a patient or legal decision-maker can void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or completing a new POLST.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date.
- The most recently dated POLST is considered the valid POLST and supersede all prior POLST directives.

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 12-31-2026
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ (Name of Patient), hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY LITTLE SHELL SERVICE UNIT-IHS
ADDRESS	ADDRESS **FAX TO 406-247-7232***
CITY/STATE	CITY/STATE 425 SMELTER AVE NE, GREAT FALLS,MT-59404- 406-247-7130

III. The purpose or need for this disclosure is: (check appropriate box(es))

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Research ☐ Other (specify) _____
☐ Health Information Exchange(IHS/Other) _____ ☐ Disability ☐ Personal Use

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (PRC, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date or expiration event)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last First MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH