Brain Health Center
Geriatric Psychiatry
12 Executive Park Dr., 5th Floor
Atlanta, GA 30329
404-728-6302

EMORY CLINIC, INC.

Thank you for allowing us to assist in your care. We look forward to meeting you.

ABOUT YOUR CARE:

- Your appointment is with members of our Emory Division of Geriatric Psychiatry clinical team who will provide a thorough evaluation and make recommendations regarding treatment for you.
- Frequently, adequate treatment requires us to work with other providers here at Emory and in the community. We will make certain you are referred to appropriate specialists and communicate recommendations with your primary care provider or other referring physician so that your medical and psychiatric care is well coordinated.
- Our team may see you several times prior to referring you back to your primary care or referring physician.
- **Please arrive 30 minutes prior to your appointment** to register. Any patient arriving more than 20 minutes late will be rescheduled.
- **CANCELLATIONS:** If you must cancel or reschedule your appointment, we require that you do so 24 hours in advance by calling **404-728-6302**. Please do this as soon as possible to avoid rescheduling delays. Appointments are not automatically rescheduled.

PLEASE BRING WITH YOU TO YOUR APPOINTMENT:

1. Completed **New Patient Information Packet** that is enclosed.
2. **All medications** in prescription bottles with your **PHARMACY ADDRESS** (not pharmacy phone #)
3. Completed **Authorization for the Release of Protected Health Information Form** (page 13)
4. **All insurance cards**, including Medicare and any secondary plans. You can fax a copy of your insurance cards to 404-712-7436 prior to the day of your appointment to decrease registration time.
5. If you have been hospitalized**,** please bring the **hospital discharge summary** or have it faxed to 404-712-7436 PRIOR to your appointment. If you need assistance obtaining your medical records, complete one copy of the Authorization for the Release of Protected Health Information form (enclosed) for each physician we need to contact and fax to 404-712-7436 or mail our office.

Again, we look forward to meeting you. Please feel free to call us at **404-728-6302** if you have any questions.

Sincerely,

William McDonald, MD
J.B. Fuqua Chair for Late-Life Psychiatry
Professor of Psychiatry and Behavioral Sciences Emory University
Director of the Geriatric Outpatient Clinic

The Emory Neuropsychiatry clinic at the Brain Health Center is a specialized clinic that provides consultations, second opinions, and patient follow-up care. Physicians are Emory Clinic faculty and fellows who have specialized training in geriatric psychiatry/neuropsychiatry. Our nurse practitioners/clinical nurse specialists (NP/CNS) have also received additional training in geriatric psychiatry/neuropsychiatry. A team of physicians and advanced practice nurses (NP/CNS) will be taking care of you. Our program is one of the largest of its kind in the United States offering a full range of neuropsychiatric evaluations, including opportunities to participate in research studies. You can find out more about our clinic and physicians on the web at www.fuquacenter.org

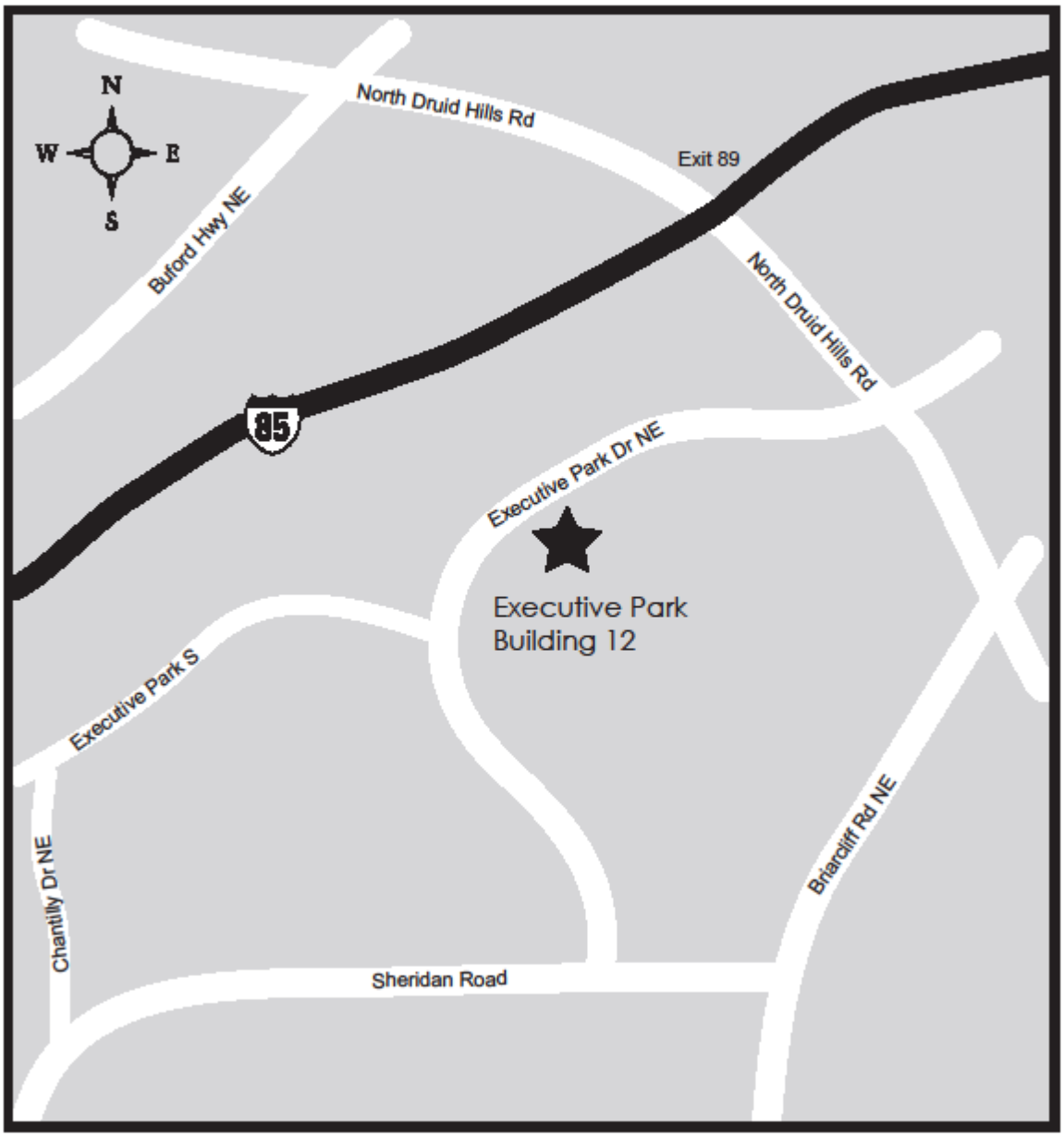
Our clinic consists of the following providers:

William McDonald, MD	JB Fuqua Chair for Late-Life Depression and Professor of Psychiatry and Behavioral Sciences Vice Chair for Education, Emory University, Department of Psychiatry and Behavioral Sciences Director, Geriatric Outpatient Clinic Certified by the American Board of Psychiatry and Neurology Added Qualifications in Geriatric Psychiatry
Larry Tune, MD	Professor of Psychiatry and Behavioral Sciences Director of Inpatient Neuropsychiatry at Wesley Woods Certified by the American Board of Psychiatry and Neurology Added Qualifications in Geriatric Psychiatry
Raymond Young, MD	Associate Professor of Psychiatry and Behavioral Sciences Certified by the American Board of Psychiatry and Neurology Added qualifications in Psychosomatic Medicine Certified by the American Board of Internal Medicine
Adriana Hermida, MD	Assistant Professor of Psychiatry and Behavioral Sciences Certified by the American Board of Psychiatry and Neurology Board Certified in Geriatric Psychiatry
Sherry Dey, MS, APRN-BC	Psychiatric Clinical Nurse Specialist Adjunct Faculty, Emory School of Nursing Certified by American Nurses Credentialing Center
Jocelyn Chen Wise, LCSW, MPH	Licensed Clinical Social Worker Project Director, Fuqua Center for Late-Life Depression

12 Executive Park Drive, NE
Atlanta GA 30329

emoryhealthcare.org/executive-park

Scan this code with your smartphone to view a map and directions.



Our building offers complimentary valet parking services. The parking deck is also free of charge. The clinic is located on the 5th floor of Executive Park Building 12.

EMORY HEALTHCARE

New Patient Information Packet

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Name of retirement home, assisted living facility or nursing home, if applicable:

_____

Preferred Contact Person: ☐ Patient □ Other _____ and Phone # _____

Family Members/Contact Persons:

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Address: _____ Address: _____

_____ _____

Telephone (Home): _____ Telephone (Home): _____

Telephone (Other): _____ Telephone (Other): _____

PHARMACY NAME_____

PHARMACY ADDRESS **(address required)**_____

_____

Referring Physician:

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Internal Medicine/Family Physician:

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

I understand that in providing this information, I am giving the staff at the Geriatric Psychiatry Clinic permission to communicate with these family members and physicians, if the need arises.

X_____

Patient's Signature (or legally authorized representative)

History of Present Illness

Please describe the main problem or the reason for making this appointment_____

_____

_____

When did symptoms begin? _____

Have you been treated for this problem before? □ Yes □ No
If yes, please describe the treatment including dates: _____

_____

_____

_____

Review of Common Symptoms

For the following symptoms, please indicate whether you are currently experiencing this, experienced this in the past, or never experienced this. **Give dates, duration of symptoms and details when applicable.**

When did this occur?			
Current	**Past**	**Never**	**Symptom**
			Depression, persistent sadness or feeling blue
			Loss of pleasure in activities
			Decreased motivation
			Crying spells
			Lack of energy or fatigue
			Loss of appetite
			Difficulty falling asleep
			Waking up multiple times during the night
			Awake early and cannot return to sleep
			Increased sleep
			Nightmares
			Difficulty concentrating
			Memory problems
			Anxious or restless
			Irritable mood
			Feelings of guilt or worthlessness
			Low self-esteem
			Feelings of hopelessness
			Self-injurious behavior (such as cutting or burning yourself)
			Feeling like you wish you were dead
			Thoughts of suicide
			Thoughts of hurting someone else
			Aggressive/combative behavior
			Racing thoughts
			Talking more than usual
			Increased activity (such as writing, cleaning, or exercising more)
			Increased risk-taking behavior
			Not eating or weight loss without trying to lose weight
			Not eating in order to lose weight

			Exercising to lose weight
			Using laxatives to lose weight
			Using other methods to lose weight
			Overeating without feeling hungry
			Binging (eating large amounts)
			Obsessive thoughts (symmetry, cleanliness, intrusive thoughts)
			Intrusive thoughts about something bad that happened to you
			Compulsive behaviors (counting, washing hands, cleaning)
			Trouble with self-care (such as dressing or bathing)
			Seeing or hearing something that others can't
			Flashbacks about something bad that happened to you
			Panic attacks
			Anxiety about social situations (such as speaking in public)
			Paranoia (suspiciousness)
			Reading other people's thoughts
			Feeling that your thoughts are being read
			Feeling like the television or radio is talking to you specifically

Have you ever been hospitalized for a mental/psychiatric illness? If so, please list dates and the hospital:

_____

_____

Medical History

Please list any serious illnesses or ongoing medical problems you have ever had. Include any surgical procedures.

Dates	**Problem**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please go to next page

Review of Symptoms
Please check any of the following that pertain to you. **Give dates, duration of symptoms and details when applicable.**

Heart Disease
□ Chest Pain
    □ At rest _____
    □ With activity _____
□ Swollen ankles _____
□ Difficulty breathing when walking or with activity _____
□ Palpitations or heart racing _____
□ High blood pressure _____
□ High cholesterol _____
□ Dizziness or fainting _____

Neurological
□ Head injury _____
□ Seizures or fits _____
□ Headaches _____
□ Falling _____
□ Problem with balance _____
□ Feels dizzy when stands up _____
□ Tremor or difficulty writing _____
□ Sleep problems such as loud snoring, gasping for breath, daytime sleepiness or limb jerking _____
_____
□ Numbness or tingling_____
□ Forgetfulness _____
□ Confusion _____
□ Difficulty speaking _____
□ Difficulty finding your way _____
□ Difficulty managing finances _____
□ Difficulty maintaining home _____

Sensations
□ Problems with sense of smell _____
□ Problems with taste _____
□ Problems with hearing _____
□ Uses hearing aid _____
□ Eye pain _____
□ Blurred or double vision _____
□ Sensitive to glare _____

Respiratory
□ Cough _____
□ Asthma or wheezing _____

Gastrointestinal
□ Problems swallowing _____
□ Burning in chest or stomach after meals or when lying down _____
□ Constipation _____

□ Diarrhea _____
□ Change in color of stool/black or tarry stools _____

Genital/urinary
□ Loss of interest in sex _____
□ Difficulty maintaining an erection _____
□ Delayed ejaculation _____
□ Pain with intercourse _____
□ Difficulty urinating _____
□ Difficulty holding urine _____
□ Trouble starting stream, dribbling or reduced stream _____
□ Pain when urinating _____
□ Need to urinate more frequently _____
□ Frequent urinary tract infections _____

Musculoskeletal
□ Difficulty standing up from sitting _____
□ Stiffness or pain in joints _____
□ Pain worse in the morning and decreases with activity _____
□ Back or neck pain _____
□ Other pain _____

Hematological
□ Anemia or low blood _____
□ Excessive bruising or bleeding _____
□ Recurrent infections or infections that will not go away _____

Endocrine
□ Thyroid disease _____
□ Weight gain or loss _____
□ Skin changes _____
□ Hair changes _____
□ Voice changes _____
□ Cold or heat intolerance _____

Allergies (List any medication, food or other allergies) _____
_____
_____

Please go to next page

Instructions: Please check the names of any medications that you have taken for at least 6 weeks since the beginning of THIS EPISODE or period of depression.

Drug Class	Generic Name	Year drug was tried	Highest Dose	# Weeks drug was taken	Was it helpful (Y/N)?	Did you experience side effects?	Did you stop due to side effects (Y/N)?
SSRI							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Prozac	Fluoxetine						
Zoloft	Sertraline						
Celexa	Citalopram						
Lexapro	Escitalopram						
SNRI							
Effexor	Venlafaxine						
Cymbalta	Duloxetine						
Pristiq	Desvenlafaxine						
Savella	Milnacipram						
Fetzima	Levomilnacipram						
Anticonvulsant							
	Lithium						
Tegretol	carbamazepine						
Depakote	Divalproex						
Neurontin	Gabapentin						
Lamictal	Lamotigine						
Trileptal	Oxacarbazepine						
Depakote	valproate						
Depakene	valproic acid						
Antipsychotics							
Abilify	Aripiprazole						
Saphris	Asenapine						
Clozaril	Clozapine						
Fanapt	Iloperidone						
Latuda	Lurasidone						
Zyprexa	Olanzapine						
Invega	Paliperidone						
Seroquel	Quetiapine						
Risperdal	Risperidone						
Geodon	Ziprasidone						

Drug Class	Generic Name	Year drug was tried	Highest Dose	# Weeks drug was taken	Was it helpful (Y/N)?	Did you experience side effects?	Did you stop due to side effects (Y/N)?
Sedatives and Sleeping Agents							
Klonopin	Clonazepam						
Xanax	Alprazolam						
Valium	Diazepam						
Benadryl	Diphenhydramine						
Lunesta	Eszopiclone						
Ativan	Lorazepam						
Serax	Oxazepam						
Restoril	Temazepam						
	Trazodone						
Halicon	Triazolam						
Sonata	Zaleplon						
Ambien	Zolpidem						
Augmenting							
Buspar	Buspirone						
Cytomel	Lioothyronine						
	Omeha 3 FA						
Stimulants							
Nuvigil	Armodafinil						
Adderal	amphetamine						
Vyvanase	Lisdexamphetamin						
Ritalin	Methylphenidate						
Provigil	Modafinil						
Other							
Strattera	Atomaxetine						
Wellbutrin	Bupropion						
Remeron	Mirtazapine						
Serozone	Nefazodone						
Edronax	Reboxatine						
Stablon	Tianeptine						
Vibryd	Vilazodone						
Brintellix	Vortioxetine						
TCA							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Endep/Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortyrptiline						

Drug Class	Generic Name	Year drug was tried	Highest Dose	# Weeks drug was taken	Was it helpful (Y/N)?	Did you experience side effects?	Did you stop due to side effects (Y/N)?
Sinequin	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protryptiline						
Azafen	Pipofezine						
Agedal/Eltrono	Noxiptiline						
Merival/Alival	Nomifensine						
MAOIs							
Marplan	Isocarboxazid						
Nardil	Phenelzine						
Parnate	Tranylcypromine						
Emsam	Selegiline patch						
Aurorix	Moclobemide						
Pirazidol	Pirlindone						

Additional Treatment Types		Approximate Dates:	Duration (weeks/months/years)	Response:
Psycho-Therapy	Cognitive Behavioral			
	Interpersonal			
ECT	Unilateral or unknown	# of Treatments		
	Bilateral	# of Treatments		

Other medications currently taking:

Medication	Dosing Schedule

Family Medical/Psychiatric History

List all of your immediate family (parents, siblings, and children). Under illnesses, list serious illnesses or diseases, especially **psychiatric/mental illnesses**.

Relationship	Age	Illness/Cause of death

Social History

Birthplace and where you were raised _____

How far did you go in school? _____ Degrees earned _____

□ Married for how long? _____ □ Divorced □ Widowed □ Single

Occupation(s) prior to retiring _____

Smoking: Number of years _____ Packs per day _____

History of alcohol abuse or addiction? _____

Alcohol: approximate drinks per week _____

Exercise: Type _____ Frequency: _____

Hobbies, interests _____

With whom do you live? _____

Please list all social/medical support services and the agency you receive them from (such as a case manager, social worker, homemaker or home health aide services, senior center, home healthcare, home delivered meals, adult protective services, etc.):

Service	**Agency Providing Service**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is there any other information you want to share with us? _____

_____

_____

_____

_____

_____

Please complete the following scale to help us assess depressive symptoms.

	Yes	No	
1	□	□	Are you basically satisfied with your life?
2	□	□	Have you dropped many of your activities and interests?
3	□	□	Do you feel that your life is empty?
4	□	□	Do you often get bored?
5	□	□	Are you hopeful about the future?
6	□	□	Are you bothered by thoughts that you can't get out of your head?
7	□	□	Are you in good spirits most of the time?
8	□	□	Are you afraid that something bad is going to happen to you?
9	□	□	Do you feel happy most of the time?
10	□	□	Do you feel helpless?
11	□	□	Do you often get restless and fidgety?
12	□	□	Do you prefer to stay at home, rather than going out and doing new things?
13	□	□	Do you frequently worry about the future?
14	□	□	Do you feel you have more problems with your memory than most?
15	□	□	Do you think it is wonderful to be alive now?
16	□	□	Do you often feel downhearted and blue?
17	□	□	Do you feel pretty worthless the way you are now?
18	□	□	Do you often worry a lot about the past?
19	□	□	Do you find life very exciting?
20	□	□	Is it hard for you to get started on new projects?
21	□	□	Do you feel full of energy?
22	□	□	Do you feel that your situation is hopeless?
23	□	□	Do you think that most people are better off than you are?
24	□	□	Do you frequently get upset over little things?
25	□	□	Do you frequently feel like crying?
26	□	□	Do you have trouble concentrating?
27	□	□	Do you enjoy getting up in the morning?
28	□	□	Do you prefer to avoid social gatherings?
29	□	□	Is it easy for you to make decisions?
30	□	□	Is your mind as clear as it used to be?

Medical Record Number: _____
(for internal purposes)

EMORY HEALTHCARE

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
HEALTH INFORMATION MANAGEMENT DEPARTMENT

Patient Name:_____ Last 4 digits of SSN: _____
Previous Name, if applicable: _____
Address:_____ City:_____ State: _____ Zip Code:_____
Date of Birth: _____ Home Phone: _____ Work Phone: _____
Email address _____

1. **EMORY HEALTHCARE FACILITY/FACILITIES:**

I authorize representatives from the following facility/facilities to disclose the health information as directed below:
(Check one or more):

- ❑ The Emory Clinic
- ❑ Emory University Hospital
- ❑ Center for Rehab. Medicine
- ❑ Emory Children's Center
- ❑ Emory Specialty Associates
- ❑ Dialysis Access Center of Atlanta
- ❑ Saint Joseph's Hospital of Atlanta
- ❑ The Medical Group of Saint Joseph's, LLC
- ❑ Emory Johns Creek Hospital
- ❑ Emory University Hospital Midtown
- ❑ Emory University Orthopaedics and Spine Hospital
- ❑ Wesley Woods Health Center
- ❑ Wesley Woods Geriatric Hospital
- ❑ Wesley Woods Outpatient Clinic
- ❑ Budd Terrace
- ❑ Other:_____

2. **RECEIVING PARTY AND METHOD OF DELIVERY:**

- ❑ Mail (Complete info below)
- ❑ Pick up (List by whom below)
- ❑ EHC Electronic Release of Information Request Website (Please provide email address above and see attached instructions)
- ❑ Via Email (Please provide email address above)

Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Fax Number (continuing patient care support only):_____

3. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**

- ❑ Complete medical record *(Please specify dates of service)*_____
  OR
- ❑ Partial Medical Record *(Please specify records below)*
- ❑ Electronic Continuity of Care/Electronic Abstract *(please specify dates of service)* _____
- ❑ *You must check this box if you are also requesting Billing Records*

Information	Dates	Information	Dates
❑ History & physical	_____	❑ Office notes/Progress notes	_____
❑ Consultations	_____	❑ Operative reports	_____
❑ Discharge summary	_____	❑ Pathology reports	_____
❑ Lab results	_____	❑ Pathology slides	_____
❑ X-rays	_____	❑ EKG reports	_____
❑ CD/Films	_____	❑ Photo/Videos	_____
❑ Cath Record	_____	❑ ED Record	_____
❑ Itemized Bill	_____	❑ Rhythm Strips	_____
❑ Other *(Please specify dates of service):*		❑ Pathology Slides	_____

4. **PURPOSE OF DISCLOSURE**

- ❑ At my request
- ❑ Other: _____

Medical Record Number: _____
(for internal purposes)

5. **Expiration of Authorization**

Unless I request in writing otherwise, I understand that this authorization will expire on _____ *(Insert expiration date or event)*. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

6. **Right to Revoke Authorization**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the Emory Healthcare facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Emory Healthcare, Inc. Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. **Re-disclosure**

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

8. **Fees**

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

9. **Refusal to Authorize Use and/or Disclosure**

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Emory Healthcare may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

10. **Release and Waiver**

If the health information that I have requested Emory Healthcare to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Emory Healthcare, each of the Emory Healthcare facilities checked above, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

_____	_____	_____
Signature of Patient (or Patient's Representative)	Date	Time
_____	_____	
Printed Name	Description of Authority to Act for Patient	

Note: a copy of this completed, signed and dated form must be provided to the patient and/or Patient's representative and a copy must be placed in the patient's medical record