ST PETER'S HEALTH PARTNERS

Cancer Care

St. Mary's Cancer Treatment Center
1300 Massachusetts Ave.
Troy, NY 12180
(518) 268-5060
fax (518) 268-5055
Samaritan Radiation Oncology
2215 Burdett Avenue
Troy, NY 12180
(518) 271-3775
fax (518) 271-3459

Dear

You have been referred to see a Medical Oncologist and/or a Radiation Oncologist. You will be seeing Dr.__________________________________.

Please refer to your folder prior to your first appointment. The right side includes important patient information and directions. The left side holds all of the forms that must be completed and brought to your first appointment. In an effort to stay on schedule for all of our patients, individuals arriving without their completed forms may be asked to reschedule their appointment. If you need help filling out the forms, please arrive 30 minutes prior to your scheduled "arrival time" and we would be happy to assist you.

Your appointment is for:

Date:
Arrival time:
Location:
Dr.

Please bring your insurance card and identification to every visit.

Please be advised that all co-payments are due on the same day the services are rendered.

If you can't make your appointment time, please call within 24 hours to reschedule.

If you have questions or concerns, or need help with your paperwork, please call us at: Hildegard Medicus Cancer Center at St. Mary's Hospital (Drs. Sunkin, Maingi and Patel) 268-5060 or Hildegard Medicus Cancer Center, Radiation-Oncology at Samaritan Hospital (Drs. Reddy and Laser) 271-3775.

Sincerely,

The Staff at the Hildegard Medicus Cancer Center

HILDEGARD MEDICUS CANCER CENTER
St Mary's Hospital
St Peter's Health Partners

HILDEGARD MEDICUS CANCER CENTER
Radiation Oncology
Samaritan Hospital
St Peter's Health Partners

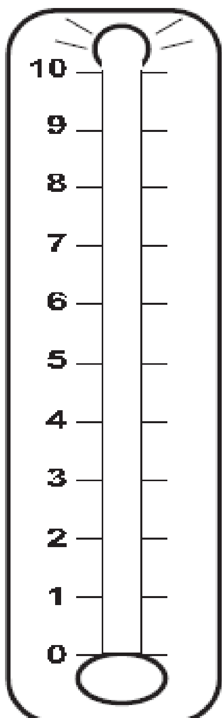
Patient Label ❑ Pre-Survey Date________ ❑ Post-Survey Date________

Research ID:

SCREENING TOOL TO MEASURE DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the last week, including today.

Extreme Distress



No Distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	**Practical Problems**
❑	❑	Child Care
❑	❑	Housing
❑	❑	Insurance/Financial
❑	❑	Transportation
❑	❑	Work/School

YES	NO	**Family Problems**
❑	❑	Dealing with Children
❑	❑	Dealing with partner

YES	NO	**Emotional Problems**
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Lost of interest in usual activity

YES	NO	**Spiritual/Religious Concerns**
❑	❑	

YES	NO	**Physical Problems**
❑	❑	Appearance
❑	❑	Bathing/Dressing
❑	❑	Breathing
❑	❑	Changes in Urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/Concentration
❑	❑	Mouth Sores
❑	❑	Nausea
❑	❑	NOse Dry/Congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin Dry/Itchy
❑	❑	Sleep
❑	❑	Tingling in Hands/Feet

Other Problems:

Total Score from Reverse Side __________

Volume 1,2005, 02-24-05 copyright National comprehensive Cancer Network, Inc. All rights reserved. These guidelines and this illustration may not be reproduced in any form without the express written permission of NCCN.

Referral to: See Below	
RN Initials	
Referral completed Date &Initials	

Additional Comments:

____

____

____

____

Implement Distress Protocol:

< 4 Low level of distress – Physician and RN team intervention.

$\geq$ 4 Severe level of distress:

Referral for Intervention: **use bolded letter(s) in key below**

Referral Key: **ACS-**ACS Navigator**; COUNS**-Counseling Services; **PN –** Patient Navigator (for breast, colon, lung or head/neck**);**
PC-Pastoral Care**; RD-** Nutrition; **PT/OT**- Rehabilitation

Volume 1,2005, 02-24-05 copyright National comprehensive Cancer Network, Inc. All rights reserved. These guidelines and this illustration may not be reproduced in any form without the express written permission of NCCN.

HILDEGARD MEDICUS
CANCER CENTER

HILDEGARD MEDICUS
CANCER CENTER

Radiation Oncology

Initial Patient History and Physical

Radiation Oncology/Medical Oncology

☐ **Arthur Sunkin, MD** ☐ **Shail Maingi, MD** ☐ **Namrata Patel, MD** ☐ **Sarada Reddy MD, FACRO**
☐ **Cheryl Syta, NP** ☐ **Christine Roe, NP** ☐ **Benjamin Laser, MD**

****

Allergies / Reaction:____
____

Patient Name____ **DOB** _____/______/_______
Home Number ________________ **Cell** ________________ **Work Number** _________________
E-mail address ____
Emergency Contact Name and Phone Number ____
Emergency Contact Relationship to You ____
Primary Care Physician __________________________________ **Number** ____________________
Surgeon (if applicable) __________________________________ **Number** ____________________
Other Doctors to whom you would like records sent: ____

****

Reason for seeing the doctor and your concerns:
____
____
____

****

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Living Arrangements ☐ Alone ☐ With Spouse/ S.O. ☐ Other______________________

Do you Drive? ☐ No ☐ Yes Means of Transportation ____________________________

Services in your Home ☐ None ☐ Aide ☐ Nurse Why?_________________________________

Please check boxes for items you have: ☐ Living Will
☐ Health Care Proxy ☐ Power of Attorney ☐ Do Not Resuscitate Orders
Would you like information on any of the above? ☐ No ☐ Yes - Information Given _________________

Please give a brief description of your prior work history: Retired ☐ No ☐ Yes
____
____
____
____

For Women Only:

Age at first Menstrual Period____________ Date of Last Period _____________________
Have you taken birth control pills? ☐ No ☐ Yes If yes, for how long____________________
Do you now use birth control? ☐ No ☐ Yes If yes, what type ____________________________
Have you ever taken hormone replacements? ☐ No ☐ Yes If yes, when ______________________
# of Pregnancies ________ # of Live Births ________ Age at 1st Child ________
Did you Breast Feed? ☐ No ☐ Yes
Year of Last: ________ Pap Test ☐ Normal ☐ Abnormal
________ Breast Exam ☐ Normal ☐ Abnormal
________ Mammogram ☐ Normal ☐ Abnormal

ARE YOU CURRENTLY
EXPERIENCING ANY OF
THE FOLLOWING?
CHECK ALL THAT APPLY.

CONSTITUTIONAL
☐ Recent Weight Loss / Weight Gain
☐ Fevers
☐ Night Sweats
☐ Excessive Itching
☐ Food Supplements
☐ On a diet now - Type ____________________
_____________Number of meals daily

EYES
☐ Glaucoma
☐ Cataracts
☐ Vision Loss
☐ Other:___________________________________

EAR, NOSE, THROAT, MOUTH
☐ Hearing Loss
☐ Dental Problem
☐ Hoarseness
☐ Nose Bleeds
☐ Other:___________________________________

CARDIOLOGY
☐ High Blood Pressure
☐ Heart Murmer
☐ Rapid/Irregular Heart Beat
☐ Chest Pain
☐ Pacemaker/Defibrillator
☐ Ankle Swelling
☐ Leg Cramps @ Night
☐ Other:___________________________________

RESPIRATORY
☐ Asthma/Bronchitis/Emphysema
☐ Shortness of Breath
☐ Cough that produces blood
☐ Other:___________________________________

GASTROINTESTINAL
☐ Loss of Appetite
☐ Heartburn or Indigestion
☐ Stomach Pain or discomfort
☐ Frequent Nausea/Vomiting
☐ Recurrent Diarrhea/Constipation
☐ Bloody Stools
☐ Black, Tarry Stools
☐ Difficulty Swallowing
☐ Other:___________________________________

GENITOURINARY
☐ Difficulty Urinating
☐ Frequent/Painful Urination
☐ Recurrent bladder infection
☐ Vaginal itching/Discharge
☐ Sexual problems
☐ Other:____________________

Please do not forget to complete right side column

▼ Office Use Only ▼

Height__________ P __________

Weight __________ R __________

BP ____________

RN Signature ___________________________

M.D. Signature _________________________

Date: _________________________________

MUSCULOSKELETAL
☐ Difficulty Walking
☐ Joint aches or stiffness
☐ Painful legs/Feet
☐ Back aches/Pain
☐ Other:______________________

NEUROLOGIC
☐ Difficulty concentrating
☐ Headache
☐ Dizziness / Fainting
☐ Numbness hands/ Feet
☐ Seizures/ convulsions
☐ Memory Changes
☐ Other:______________________

PSYCHOSOCIAL
☐ Nightmares
☐ Anxious/Nervous
☐ Trouble Sleeping
☐ Lonely/ depressed
☐ Work/ Family Problems
☐ Tire easily
☐ Other:______________________

ENDOCRINE
☐ Thyroid Problems
☐ Blood Sugar Problems
☐ Excessive sweating
☐ Other:______________________

SKIN/ BREAST
☐ Sores/ Rashes
☐ Moles
☐ Nipple Discharge
☐ Change in Breast Size
☐ Lump/Pain
☐ Other:______________________

HEMATOLOGIC/ LYMPHATIC
☐ Easy bleeding / bruising
☐ Anemia or blood problems
☐ Frequent infections
☐ Swelling of glands
☐ Swelling of hands/ Feet
☐ Other:______________________

ALLERGIC/ IMMUNOLOGIC
☐ Facial Swelling
☐ Tightness of throat
☐ Hives
☐ Other:______________________

HILDEGARD MEDICUS CANCER CENTER

St Mary's Hospital
ST PETER'S HEALTH PARTNERS

HILDEGARD MEDICUS CANCER CENTER
Radiation Oncology

Samaritan Hospital
ST PETER'S HEALTH PARTNERS

Initial Patient History and Physical

Do you now or have you ever:

Smoked Cigarettes ☐ No ☐ Yes If yes, packs per day______ # of years ______Year quit ______
Consumed Alcohol ☐ No ☐ Yes If yes, drinks per week ___________
Consumed Coffee/Tea ☐ No ☐ Yes If yes, cups per day _____________
Used Illegal Drugs ☐ No ☐ Yes If yes, type and when used _____________________________

Medical History: Please check the boxes next to the appropriate diagnosis

☐ Heart Condition ☐ Stroke ☐ A Lung Disorder
☐ Stomach/Gall Bladder Problems ☐ Jaundice/Hepatitis/other Liver Disorders
☐ Ulcerative Colitis/Crohns Disease ☐ Kidney/Bladder Problems
☐ Sexual Problems ☐ AIDS ☐ Veneral Disease/Herpes
☐ Arthritis / Chronic Pain ☐ Chicken Pox ☐ Frequent Headaches/Nervous Disorder
☐ Seizure Disorder ☐ Depression ☐ Thyroid Problems
☐ Diabetes ☐ Eczema/Skin Disorders ☐ Breast Problems
☐ Anemia/Blood Disorders ☐ Prostate Problems ☐ Influenza Vaccine _______ when
☐ Asthma/Hives ☐ Birth Defects/Inherited Diseases
☐ Measles/Mumps/Rubella ☐ Other Medical Problem ☐ Pneumonia Vaccine _______ when

If you checked any box above please explain:____

____
____
____
____
____

Any Prior Cancer Treatment ☐ No ☐ Yes If yes, what type of cancer ______________________
What year were you treated _____________________________________
Where were you treated ____

Do you currently have Pain ☐ No ☐ Yes If yes, where ____________________________________
What medications do you take for pain _________________________________
Who is treating your pain ____
Are you afraid to take pain medication ☐ No ☐ Yes

Please list any serious hospitalizations or prior surgeries:
(Any metal/hardware or implants in your body including pacemakers)

Month / Year	Illness or Operation	Complications
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

HILDEGARD MEDICUS
CANCER CENTER

HILDEGARD MEDICUS
CANCER CENTER

Radiation Oncology

Initial Patient History and Physical

Please list family history below:

Family History	Present Age	Age at Death	Cancer History	Present Health or Cause of Death
Father				
Mother				
Siblings				
Siblings				
Siblings				
Children				
Children				
Children				

Your Pharmacy Name____

Pharmacy Address____

Pharmacy phone number____

Allergies/reactions:____

Please list all medications that you currently take:

Medication Name	Dose	How often and Why do you take?	MD ordering Medication

I consent to the photographing of myself for clinical identification reasons, to record and monitor clinical course of therapy, and for educational purposes.

Patient Signature ______________________________________ Date ____________

****
****

To be completed by Office:

Reviewed by ______________________________________ Date: ______________________

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document.
Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.

2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.

3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.

4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.

5. You do not need a lawyer to fill out this form.

6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.

7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.

10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.

11. Appointing a health care agent is voluntary. No one can require you to appoint one.

12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care

agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe

deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

Can my health care agent make decisions for me about organ and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; or a guardian appointed by a court prior to the donor's death.

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about____________ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse , if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, ____

hereby appoint ____
(name, home address and telephone number)

____

____

*as my health care agent to make any and all health care de*cisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint ____
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: ______________________

____

____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: ______________________

____

____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name ______________________________

Your Signature ______________________________ Date ______________

Your Address ______________________________

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues ______________________________

____

☐ Limitations ______________________________

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature ______________________ Date ______________________

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date ______________________ Date ______________________

Name of Witness 1 *(print)* ______________________ Name of Witness 2 *(print)* ______________________

Signature ______________________ Signature ______________________

Address ______________________ Address ______________________

______________________ ______________________

Department of Health

Hildegard Medicus Cancer Center at St. Mary's Hospital:

From Albany: Take I-787 North to Exit 9E (Troy/Bennington Route 7). Proceed east over the Collar City Bridge and onto Hoosick Street. At 2nd traffic light, turn left onto 10th St./Oakwood Ave. Bear right at split in road. Take 2nd right onto Sausse Ave. Take 1st left. Entrance is to the left and parking is both left and right or in the parking garage.

From Latham: Take Route 7 East, over the Collar City Bridge and onto Hoosick Street. At 2nd traffic light, turn left onto 10th St./Oakwood Ave. Bear right at split in road. Take 2nd right onto Sausse Ave. Take 1st left. Entrance is to the left and parking is both left and right or in the parking garage.

From Vermont: Take Route 7 West for approximately 25 miles to Troy NY. Turn right onto 10th St./ Oakwood Ave. Bear right at split in road. Take 2nd right onto Sausse Ave. Take 1st left. Entrance is to the left and parking is both left and right or in the parking garage.

Hildegard Medicus Cancer Center at Samaritan Hospital:

From Albany: Take I-787 North to Exit 9E (Troy/Bennington Route 7). Proceed east over the Collar City Bridge and onto Hoosick Street. At 5th traffic light, turn right onto Burdett Ave. Proceed to the second traffic light marked People's Ave; turn right and watch for the "Outpatient Services" Lally Pavilion entrance sign on the right. Parking is available adjacent to the outpatient entrance.

From Latham: Take Route 7 East, over the Collar City Bridge and onto Hoosick Street. At 5th traffic light, turn right onto Burdett Ave. Proceed to the second traffic light marked People's Ave; turn right and watch for the "Outpatient Services" Lally Pavilion entrance sign on the right. Parking is available adjacent to the outpatient entrance.

From Vermont: Take Route 7 west for approximately 25 miles to Troy NY. Turn left onto Burdett Ave. Proceed to the second traffic light marked People's Ave; turn right and watch for the "Outpatient Services" Lally Pavilion entrance sign on the right. Parking is available adjacent to the outpatient entrance.

HILDEGARD MEDICUS CANCER CENTER
1300 Massachusetts Avenue
Troy, New York 12180
ph 518.268.5060

sphp.com

Welcome to the Hildegard Medicus Cancer Center

In order to better assist you – please refer to the following

Scheduling changes, new appointments or questions

Please dial **268-5060 and press option #1**. If we are unavailable, please leave a message and we will get back to you as soon as possible. If it is an emergency, please hang up and dial **911** or go to the nearest emergency room.

Prescriptions:

If you need a prescription refilled, you must call our main line at **268-5060** and select option 3. If we are unavailable, please leave a message detailing your name, date of birth, your phone number, pharmacy name and the specific drug and dosage that you need refilled. Please note that all refills will require **3 business days** to be filled. Auto request refills from pharmacies will **NOT** be honored. Prescriptions will longer be refilled after hours or on weekends.

Paperwork:

Disability, Out of work letter, Housing application, Request for Medical Records or any paperwork that needs to be signed by the physician or validated by this office must be dropped off to the front desk. We do require **2 business days' notice** to complete any paperwork.

Contact us to let us know of any health issues, concerns or questions that you may have. Please never hesitate to contact the appropriate number so that we can meet your needs in a timely manner. We are here to accompany you on every step of your journey.

MEET THE ONCOLOGY TEAM *at the Hildegard Medicus Cancer Center*

HILDEGARD MEDICUS CANCER CENTER - MEDICAL ONCOLOGY

Arthur Sunkin, MD, *Chief*

Internal Medicine, Oncology

Board Certification: American Board of Internal Medicine, American Board of Medical Oncology
Residency: Dartmouth-Hitchcock Medical Center, Lebanon, NH
Fellowship: Dartmouth-Hitchcock Medical Center, Lebanon, NH
Education: The George Washington University of Medicine and Health Sciences, Washington, DC

Shail Maingi, MD

Internal Medicine, Oncology

Board Certification: American Board of Internal Medicine, American Board of Hospice and Palliative Medicine, American Board of Medical Oncology, American Board of Hematology
Residency: Montefiore Medical Center, Bronx, NY
Fellowship: Memorial Sloan Kettering Cancer Center, New York, NY, and Montefiore Medical Center, Bronx, NY
Education: Temple University School of Medicine, Philadelphia, PA

Namrata Patel, MD

Oncology

Board Certification: American Board of Medical Oncology, American Board of Hematology
Residency: SUNY Stony Brook, Stony Brook, NY
Fellowship: New York University Medical Center, New York, NY
Education: Mount Sinai School of Medicine, New York, NY

Christine Roe, FNP

Nurse Practitioner

Board Certification: American Academy of Nurse Practitioners
Education: Upstate Medical University, Syracuse, NY

Cheryl Syta, AOCNP

Advanced Oncology Nurse Practitioner

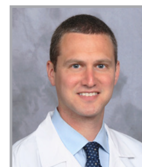
Board Certification: Oncology Nursing Certification Corporation
Education: University at Buffalo, Buffalo, NY

HILDEGARD MEDICUS CANCER CENTER - RADIATION ONCOLOGY

Sarada Reddy, MD, FACRO

Radiation Oncology

Board Certification: American Board of Radiology
Residency: Wayne State University, Detroit, MI
Education: Kilpauk Medical College, Chennai, India



Benjamin Laser, MD

Radiation Oncology

Board Certification: American Board of Radiology
Residency: Henry Ford Hospital, University of Maryland
Education: University of Maryland, School of Medicine, Baltimore, MD

Medical professionals are invited to contact us for consultations or patient referrals.

HILDEGARD MEDICUS CANCER CENTER - MEDICAL ONCOLOGY
St. Mary's Hospital
1300 Massachusetts Avenue, Troy NY
ph (518) 268-5060

HILDEGARD MEDICUS CANCER CENTER - RADIATION ONCOLOGY
Samaritan Hospital
2215 Burdett Avenue, Troy, NY
ph (518) 271-3775

ST PETER'S HEALTH PARTNERS
Cancer Care

sphp.com | sphpma.com

HILDEGARD MEDICUS CANCER CENTER

St Mary's Hospital
ST PETER'S HEALTH PARTNERS

HILDEGARD MEDICUS CANCER CENTER

Radiation Oncology

Samaritan Hospital
ST PETER'S HEALTH PARTNERS

PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

1. **Receive considerate and respectful care.**
2. **Receive services without regard to race, color, age, ethnicity, religion, sex, sexual orientation or source of payment.**
3. **Know the names, positions and functions of any staff involved in your care.**
4. **Be fully informed of your treatment plan and participate in its development. This includes setting goals and measuring progress with your provider.**
5. **Receive all information you need to give informed consent for any treatment or procedure.**
6. **Refuse treatment and be told what affect this may have on your health.**
7. **Obtain, in writing, an explanation of the reason(s) for your discharge from treatment in the center. And, if necessary, receive help obtaining treatment at another program.**

You have the responsibility to:

1. **Provide 24 hour notice if you cannot keep your appointment with our office.**
2. **Call when you have more than 48 hours of your prescription left.**
3. **Tell the doctor or nurse if you do not understand your treatment.**
4. **Act responsibly and cooperate with staff and providers.**
5. **Respect the right of the other patients to receive confidential treatment.**
6. **Pay for treatment on a timely basis, according to your means.**
7. **Ensure that you and your visitors comply with the Cancer Center Code of Conduct**

______________________________ ____________________

Patient Signature **Date**

CANCER CENTER CODE OF CONDUCT

Please help us maintain a healing environment for our patients.

We ask that you comply with the following visitor rules:

- **Respect a patient's right to privacy.** Federal law requires that hospitals comply with strict laws to protect patients' privacy.
- **Do not visit if you are sick or have an illness that could be transmitted to a patient.**
- **Children must be supervised at all times. Children under 16 aren't allowed in the treatment area.**
- **Be respectful and courteous of both patients and the center's staff.**
- **Avoid using inappropriate, obscene or insulting language.**
- **Visitors are required to dress appropriately.**
- **No photography is allowed in patient care areas, including pictures taken by cellphone.**

You will be asked to leave for violating any of the above rules or for the following:

- **Your behavior creates a risk or threat to patients, families or staff.**
- **Exhibit disruptive, threatening or violent behavior of any kind.**
- **You appear to be ill.**
- **You refuse to follow staff instructions.**
- **You are not respectful or considerate of others.**
- **You fail to supervise children.**
- **Disruptive cell phone use.**

Enforcement/Compliance: All healthcare staff and employees are responsible for the enforcement of this policy.

Being a visitor at the center is a privilege which can be revoked. Visitors who do not comply with this Code of Conduct will be asked to leave the centers property and may be escorted by security.

Thank you for your cooperation.