Sari Center
Integrative Cancer Care
MIND • BODY • SPIRIT

CAREGIVER DATA SHEET
(i.e. spouse, family member, friend of cancer patient)

NAME: _____ DATE: _____
Last First

AGE: _____ DOB: _____ RACE: _____ Gender: Male ☐ Female ☐

EMAIL: _____ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Other**

ADDRESS: _____
Street/Apt # City State Zip

PHONE #: _____ _____
Home Cell

OCCUPATION: _____ WORK #: _____

CANCER PATIENT'S NAME: _____ RELATIONSHIP: _____

YOUR PRIMARY CARE PHYSICIAN:

_____ _____
Name Phone

EMERGENCY CONTACT (other than patient):

_____ _____
Name/Relationship Phone

IS FLORIDA YOUR PRIMARY RESIDENCE?
circle YES or NO (If no, please provide primary residence information):

_____ _____
Street/Apt # City State Zip Phone

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Consent Form

I _____ hereby give informed consent for myself to participate in the integrative cancer care program offered by the Sari Asher Center for Integrative Cancer Care ("Sari Center"), an initiative of the Palm Beach Cancer Institute Foundation, Inc. ("PBCIF"). I understand that the services rendered may include: massage therapy, reflexology, acupuncture, counseling, education, yoga/guided meditation, Qi Gong, stretching & flexibility classes, support groups, nutrition consultation, Healing Touch, lymphedema treatment, hypnotherapy, and any other complementary cancer therapy treatments as coordinated by the Sari Center interdisciplinary team in collaboration with my physician. I acknowledge that the Sari Center is an integrative center and does not offer "alternative" therapies in lieu of traditional medical treatment.

I recognize that services are rendered without distinction due to race, color, nationality, handicap, age, gender, sexual orientation, or socioeconomic status. I understand that these services are provided in person only at the Sari Center or in some cases, specifically designated PBCI satellite locations. I acknowledge that fees for service are designated in writing at the time of my initial assessment, and payment is due at the time of treatment or in the event of a cancellation.

I am aware that the Sari Center therapists are licensed and trained professionals qualified to provide the services advertised, however I recognize that some of my needs may not be met via the integrative therapies offered. I understand that if necessary, and at the discretion of the professionals, I will be referred to my physician and/or other organization for services not provided by Sari Center treatment providers, in some cases resulting in discharge.

In addition, I understand that a parent/guardian's consent for participation is required if minors under the age of eighteen (18) are included in Sari Center programs.

The Sari Center adheres to all HIPAA laws of privacy. By providing my signature below, I acknowledge receipt of the **Notice of Privacy Practices** for Personal Health Information (PHI), and that I understand PHI uses and reasons for disclosure. While I understand that the Sari Center interdisciplinary team respects confidentiality of the patient as pursuant to Florida law and federal HIPPA regulations, I also understand that the Florida State law requires the reporting of any suspected abuse, neglect, or exploitation of a child or elderly person.

I understand that I am fully responsible for all of my personal articles (money, jewelry, clothing, etc.) while I am receiving Sari Center services. I hereby fully release the Center and PBCIF from any and all liability resulting from a loss by whatever means.

Finally, I acknowledge that I have read, understand, and have been provided with copies of the Center's **Cancellation Policy**, the **Patient Bill of Rights & Responsibilities**, the **Patient Code of Conduct, and the PET/CT Scan Policy**. I understand that my eligibility for continued receipt of services at the Sari Center is contingent on my compliance as designated on the above mentioned policies, and that termination of services may result in cases of violation.

_____ _____

Patient Signature **Date**

_____ _____

Employee Signature **Date**

Sari Asher Center for Integrative Cancer Care
3401 PGA Blvd. #200
Palm Beach Gardens, FL 33410

PATIENT NAME: _____ DATE: _____

CAREGIVER ASSESSMENT FORM

I. MEDICAL STATUS

1. Do you have any medical conditions/issues we need to know about?

   _____

   _____

2. List your current routine or as-needed prescriptions, including vitamins, supplements, and over the counter medications:

   _____

   _____

   _____

   _____

   _____

II. PRESENTING INFORMATION

1. What is your primary reason for coming to the Sari Center?

   _____

   _____

2. Please check off your symptoms/areas of concern:

___ pain	___loss of appetite	___anxiety
___fatigue/weakness	___weight loss/gain	___depression
___neuropathy	___nausea/vomiting	___grief & loss
___lymphedema	___diarrhea	___sleep disturbance
___balance/mobility issues	___swallowing issues	___marital/relationship issues
___smoking	___nutrition questions	___family/caregiver issues
___recent recurrence	___special diet	___employment/financial issues

3. Of the problems identified above, please prioritize the areas of concern you wish to address at the Sari Center:

   _____ _____ _____

PATIENT NAME: _____ DATE: _____

4. Please circle the number from 0-10, (0 being "the worst it has been lately," compared to 10 being "the best it has been lately") that best describes your present status:

My Physical Status

(how my body feels overall – considering my energy, pain, sleep, nausea, appetite, etc.)

0 1 2 3 4 5 6 7 8 9 10

My Emotional Status

(my mood in general- considering my anxiety, depression, fearfulness, etc)

0 1 2 3 4 5 6 7 8 9 10

My Personal Relationships/Support System

(how I rate the support of my relationships with my partner/spouse, family, friends, etc.)

0 1 2 3 4 5 6 7 8 9 10

My Overall Quality of Life

(how I rate my **actual** quality of life in general, *at this time*)

0 1 2 3 4 5 6 7 8 9 10

III. NOTES

Please let us know if you have any additional concerns or issues you would like us to be aware of right now.

_____

_____

_____

_____

Patient Name: _____ Date_____

MONTHLY INCOME WORKSHEET

INCOME SOURCE	AMOUNT
EMPLOYMENT	
Yours:	
Spouse/Sig. Other's:	
Total Household Employment:	
Unemployment:	
Disability:	
Alimony:	
Child Support:	
Food Stamps:	
Pension/Retirement/IRA:	
Social Security:	
Draw From Savings:	
Other Source(s):	
TOTAL MONTHLY INCOME:	

Household Size____ Adults _____ Children

I hereby attest that the informaion regarding my monthly income status has been fully and honestly disclosed, and that the figures are accurate.

_____ _____

Signature Date