thesecondopinion

Compassion, Clarity, Choice

INSTRUCTIONS

Thank you for contacting **thesecondopinion**. Our service is available to any adult diagnosed with cancer living in California who is able to attend a second opinion panel *in person* at our San Francisco office.

You will be contacted with your appointment date ***after*** we have received the following enclosed completed paperwork from you:

A.

FORM I : Registration and Authorization
FORM 2: Medical Intake
FORM 3: Release of Information
FORM 4: Physicians and Medical Facilities
FORM 5: Statistical Questionnaire

MAIL TO : THE SECOND OPINION
1200 Gough Street, Suite 500
San Francisco, CA 94110

email: mail@thesecondopinion.org

FAX: 415-346-8652

We will request all your medical records, pathology slides and radiology from our office - unless you tell us that you prefer to collect them yourself. (Read below)

If you choose to collect your records yourself, please notify us. You will need to provide each physician's office or clinic (see "B." below) and each Hospital Department (see "C." below) with a separate copy of your completed Release of Information form.
The following information needs to be requested:

B. From each private doctor's office or clinic (surgeon, medical oncologist and/or radiation oncologist)**:**

1. Copies of **Medical records** relating to your cancer diagnosis, including, if possible, a **short medical summary** from your medical oncologist and/or radiation oncologist.

C. From your hospital or medical center (Each **Department** must be provided with a **separate copy** of your completed **FORM 3: Release of Information** as follows):

1. **Medical Records Department:** Medical records pertaining to your cancer diagnosis, to include surgical reports, consultation reports, hospital discharge summaries and outpatient clinic visits.

2. **Pathology Department:** Pathology slides and reports related to your cancer diagnosis

3. **Radiology Department:** X-rays and scans (CT, MRI, PET) and reports related to your cancer diagnosis.

It may take a few weeks to complete your file. Once our Medical Director determines that your materials are complete, we will call to schedule you for the next available panel date.

On your scheduled panel day, you will meet with your physician panel to discuss your case, ask your questions and hear their recommendations. Following the panel, a second opinion letter will be mailed to you and your physicians.

Again--please be sure to notify us as soon as possible if you wish to acquire your medical records, pathology slides and radiology films yourself.

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provided by the Regional Cancer Foundation

FORM I : REGISTRATION and AUTHORIZATION

THIS AUTHORIZATION APPLIES TO ALL MEDICAL RECORDS, MATERIALS AND INFORMATION PROVIDED TO THE SECOND OPINION

I am requesting a Second Opinion concerning my cancer diagnosis and treatment. By signing this document I am authorizing **thesecondopinion** to access my medical information and share it with physicians/medical specialists associated with **thesecondopinion** service for the purpose of providing a medical consultation to me and my treating physicians.

I understand that my records will be seen by employees of **thesecondopinion**, who will distribute them only to the physicians and medical specialists involved in providing my second opinion. All of my information will remain confidential. This authorization also applies to any updated information that I may bring to my second opinion meeting on my panel date.

I also give permission to provide a follow-up second opinion letter to myself and my treating physicians, whom I shall designate at the time of the panel session.

I understand that **thesecondopinion** charges no fees for its services.

I understand that I may revoke this authorization in writing at any time.

This authorization expires one year from the date shown below or upon my revocation, whichever occurs earliest.

Patient Signature: _____ Date: _____

Address: _____

_____

_____

Phone: _____

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Medical Intake Form--Form II

Name: _____ **Date of Birth:** _____ **Sex:** _____

Email: _____ **Phone:** _____
Home Mobile

Address: _____

Contact person, if other than patient: _____

Contact person's phone and or email : _____

Type of Cancer: _____

When were you diagnosed with cancer? _____

Have you received a prior Second Opinion? _____ **If so where and when?** _____

Are you planning to Obtain Additional Opinions? _____ **If so where and when?** _____

☐ **I will need the help of translator services.** Which Language? _____

How did you hear about us?

Why are you seeking a second opinion?

Please tell us briefly about your cancer diagnosis and treatment to date. This will help us determine the records that will be needed for your panel review:

Feel free to use the back of this page if you need additional space

FORM III

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PATIENT HEALTH INFORMATION RELEASE FORM

I HEREBY AUTHORIZE:

_____

NAME OF HOSPITAL, DOCTOR, LABORATORY OR DEPARTMENT

_____

ADDRESS

_____

CITY STATE ZIP CODE

TO RELEASE TO: **Howard B. Kleckner, MD**
Medical Director
The Second Opinion
1200 Gough Street – Suite 500
San Francisco, CA 94109

RECORDS AND INFORMATION OF:

_____ _____ _____

PATIENT NAME MEDICAL NUMBER DATE OF BIRTH

_____ _____

ADDRESS TELEPHONE NUMBER

INTENDED USE: CANCER CONSULTATIVE PANEL

Duration: I understand that this authorization is effective immediately and shall be valid for one year.
Right to Revoke: I understand that I may revoke this authorization in writing at any time.
Reuse: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.

RECORDS TO BE RELEASED:

- ☐ MEDICAL RECORDS RELATED TO CANCER DIAGNOSIS, INCLUDING LAB REPORTS, CONSULTATIONS, OPERATIVE REPORTS AND PATIENT SUMMARIES.
- ☐ X-RAYS AND REPORTS, CT scans, MRIs and REPORTS
- ☐ PATHOLOGY SLIDES AND REPORTS
- ☐ NUCLEAR SCANS AND REPORTS

Patient signature: _____ Date: _____

FORM IV: PHYSICIANS and MED INFO

Date: _____

Name: _____ **Phone:** _____
Home Mobile

Email: _____ **Type of Cancer:** _____

Have you received a prior Second Opinion? ____ **If so where and when?** _____

Are you planning to Obtain Additional Opinions? ____**If so where and when?** _____

☐ **I will need the help of translator services.** Which Language? _____

To the best of your knowledge, please list all physicians and medical facilities involved in your care. Addresses and phone numbers are appreciated.

Oncologist: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Surgeon: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Radiation Oncologist: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Other Specialist: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Hospital/Facility:

Medical Records Department: _____
Address: _____

Radiology Department: _____
Address: _____

Pathology Department: _____

Address: _____
Other Department: _____
Address: _____

Feel free to use the back of this page if you need additional space.

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FORM V: STATISTICAL QUESTIONNAIRE

Name: (initials) _____ **Age:** _____ **Date:** _____ **Sex:** _____

Type of Cancer: _____

How did you hear about our service? _____

The information below is used only to provide statistics to potential funding organizations. No names will be used.

Ethnic identity: ***(Please circle each identity that applies to you)***

African American Latino/Hispanic Pacific Islander Asian
Native American White Multi-Racial Other

Are you: *(Please circle one)* Single Married Widowed Divorced

Are you: *(Please circle all that apply)*

Employed Retired Unemployed On Disability other

Annual *Combined* **Household Income:** *(Please circle one below):*

$50,000 or Less $51,000 -$79,000 80,000-100,000 $101,000 or Above

Is your medical care covered by *(Please circle all that apply)*:

Medical insurance Medi-Cal Medicare No coverage Other

Our consultative services are completely free of charge. We will not bill you or whoever covers your health care. But we would like to know if you have coverage for the costs for second opinions, even if outside your health plan network?

Yes Partial with Co-Pay No I don't know

Thank you for providing this information to ***thesecondopinion.***