THE STEADMAN CLINIC

Peter Millett, MD
Shoulder, Elbow & Knee Specialist
Sports Medicine
970-479-5871: Tel
970-479-5861: Fax

CLINICAL CASE AND MRI REVIEW

Dr. Peter Millett welcomes your *Clinical Case and MRI Review* for a fee of $250. After Dr. Millett has reviewed all of the information regarding your case, he will email or call you directly with the results.

To initiate a *Clinical Case and MRI Review* with Dr. Millett, please follow the instructions below to prepare a package to be mailed to our office:

- Print out and complete the Patient Consent Form and Clinical History Form
- Gather ALL imaging on a disk (X-Ray, MRI, CT-SCAN)
- Gather and send ALL radiology reports and interpretations of the image studies
- Include check or complete the payment authorization form in this packet
- Please email a copy of your insurance card (front and back) to Dr. Millett's Surgical Coordinator, Amanda Rakow: arakow@thesteadmanclinic.com. This will aide in expediting the scheduling process if you decide to pursue further treatment with Dr. Millett after your image review.

*****We recommend patients gather and mail their own materials in order to avoid delays and shipping errors from image centers and/or clinics.*****

Once all forms are complete, imaging has been gathered, and payment has been rendered, please mail the package to our Surgical Coordinator, Amanda Rakow as follows:

The Steadman Clinic
181 West Meadow Drive Suite 400
Vail, CO 81657
Attn: Amanda Rakow

Please direct any questions regarding this process to Amanda Rakow at 970-479-5879.

We look forward to the opportunity to help you!
Dr. Millett and Team

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Clinical Case and MRI Review Patient Consent Form

Consent for Clinical Case and MRI Review &
Authorization for the Release of Medical Information

Patient Information

Name: ____________________________________
Address: ____________________________________
____
Date of Birth: ____________________________________
Preferred Phone: ____________________________________
Email Address: ____________________________________

☐ I am 18 years or older. ☐ I am under the care of a physician

Because there is not an opportunity for a physical examination, this Clinical Case and MRI Review differs from diagnostic services typically provided by a physician. Without the benefit of examining you in person and observing your physical condition, Dr. Millett may not be aware of facts or information that could influence or be critical to his opinion. By requesting this service, you acknowledge that you are aware of this limitation and agree to assume the risk of this limitation.

Please read the following and indicate agreement to each paragraph by checking the "I agree" box below that paragraph:

I understand that the Clinical Case and MRI Review that I will receive from Dr. Millett is preliminary and limited because it does not have information typically obtained through a physical examination. The absence of a physical examination could affect Dr. Millett's ability to diagnose my condition or injury. This Clinical Case and MRI Review is not intended to replace a full medical evaluation or an in-person visit with a physician. I agree to solely assume the risks of the limitations associated with this review and understand that no warranty or guarantee is made to me concerning a specific result or cure of my condition or injury. I have read and agree to be bound by these conditions.

☐ Yes, I agree ☐ No, I do not agree

I have received the Notice of Privacy Practices of The Steadman Clinic and understand the explanation of how they may use and disclose confidential health information that identifies me. I consent to let The Steadman Clinic use and disclose health information about my Clinical Case and MRI Review. I can revoke my consent in writing at any time except to the extent that The Steadman Clinic has already relied on my consent.

☐ Yes, I agree ☐ No, I do not agree

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Authorization for Clinical Case and MRI Review

I understand that if I do not sign the below authorization, Dr. Peter Millett will not be able to provide me with a Clinical Case and MRI Review. I also understand that any disclosure that The Steadman Clinic makes to a third party, may or may not be protected by privacy laws.

This authorization is subject to revocation at any time, except to the extent that action has been taken thereon, and this authorization will expire one year from the date of authorization written below.

____________________________	____________________________	_____/_____/____
Signature of Patient**	Printed Name	Date Signed

**If other than patient's signature, a copy of legal papers verifying authority (e.g., Power of Attorney, Legal Guardian) must accompany the authorization when presented. The form must be signed, dated, witnessed by two people, and notarized when possible.

Exception: parent is signing for patient under 18.

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Payment Authorization Form

We accept both checks and credit cards for an MRI review payment. For those writing a check, please make the check payable to *The Steadman Clinic* for the amount of $250.

If you are paying by credit card, please complete the information below.

Sign and complete this form to authorize The Steadman Clinic to make a one time debit to your credit card listed below. By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

I ____________________ authorize The Steadman Clinic to charge my credit card for **$250**. This
(Full Name)

payment is for an MRI review with Dr. Millett of The Steadman Clinic.

Billing Address __________________
City, State, Zip ___________________
Phone Number __________________
Email _________________________

Account Type (circle): Visa Mastercard AMEX Discover

Card Holder Name _______________________
Account Number ________________________
Expiration Date _________________________
CCV/CVV Code (three-digit security number on the back of Visa®, Mastercard®, and Discover® and four-digit code on the front of American Express®) ___________

SIGNATURE ____ DATE ____________

I authorize The Steadman Clinic to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form.

INITIAL EVALUATION FORM
Peter J. Millett, M.D., M.Sc.
Shoulder, Knee, Elbow Surgery / Sports Medicine

Name: ______________________________
Age: __________ Today's Date: ______________
Date of Birth: ______________________
Height: ____________ Weight: ____________
Who referred you to us?
____
____

Current Occupation:
____

Where is your problem? (please circle)

Shoulder ☐ Knee ☐ Elbow ☐
Neck ☐ Back ☐ Other ☐

Side: Left / Right / Both
Dominant Arm: Left / Right
Problem: (check all that apply)

- ☐ Pain
- ☐ Weakness
- ☐ Instability / giving way / dislocation
- ☐ Stiffness
- ☐ Swelling
- ☐ Other ______________________

How did you injure yourself?

- ☐ No injury
- ☐ Sports (specify) ______________________
- ☐ Motor Vehicle Accident
- ☐ Work/Job

Workers Comp claim: Yes ☐ / No ☐
Sports Level: None / Recreational / College / Pro
Date of Injury: ______________________
How long have you had symptoms?
____

Briefly describe injury: ______________________
____

Diagnosis (if known): ______________________
____

Previous non-surgical treatments: (meds, physical therapy, injections, bracing)
____
____

Previous surgery for this problem (with dates)
____
____

How severe is the pain? (0=none, 10=severe)

At rest: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
At its worst: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Pain at night: Yes / No
Pain wakes you from sleep: Yes / No
Are you currently working? Yes / No / Retired
Job duties level: Normal / Limited
Interested in surgery: Yes / No / Unsure

What makes your problem better?
____
____

What makes your problem worse?
____
____

Describe your current limitations:
____
____

Previous imaging studies for this problem:

X-rays	Yes / No	Date: ________
MRI	Yes / No	Date: ________
CT	Yes / No	Date: ________

MEDICAL HISTORY:

- ☐ High blood pressure ______________________
- ☐ Heart problems ______________________
- ☐ Heart attack ______________________
- ☐ Stroke ____________ ☐ Seizures ____________
- ☐ Asthma ____________ ☐ Gastritis ____________
- ☐ Kidney disease ____________ ☐ Cancer ____________
- ☐ Osteoporosis ______________________
- ☐ History of blood clot/embolus ______________________
- ☐ Blood clotting disorder ______________________
- ☐ Diabetes ______________________
- ☐ History of skin infections ______________________
- ☐ MRSA ______________________

MEDICATIONS: (please all current medications)

____

____

____

ALLERGIES: Allergic to latex: Yes / No
Allergies to medications: None / ______________________________________

SOCIAL HISTORY: Marital Status: __________________ Residency: ______________________
Alcohol use: Daily / Socially / Never Tobacco Use: Yes / No / Former

FAMILY HISTORY: (please list diseases that run in your family)

____

____

Family history of blood clots: Yes / No ____________ Family history of bleeding disorders: Yes / No ____________

REVIEW OF SYSTEMS: (circle all that apply)

1. CONSTITUTIONAL/GENERAL: None / Recent weight change / Chills / Fever / Weakness or fatigue

____

2. EYES: None / Vision change / Glasses or contacts / Cataracts / Glaucoma / Other

____

3. EARS, NOSE, THROAT: None / Hearing loss / Earache or infection / Ringing in ear / Hoarseness / Other

____

4. CARDIOVASCULAR: None / Chest Pain / Swelling in legs / Shortness of breath / Palpitations / Other

____

5. RESPIRATORY: None / Shortness of breath / Wheezing or asthma / Frequent cough / Other

____

6. GASTROINTESTINAL: None / Heartburn / Acid reflux / Nausea or vomiting / Abdominal pain / Other

____

7. MUSCULOSKELETAL: None / Arthritis or joint stiffness / Muscle aches / Swelling of joints / Other

____

8. SKIN: None / Rash / Ulcers / Abdominal Scars / Sores / Other

____

9. NEUROLOGICAL: None / Headaches / Fainting or blackouts / Dizziness /
Numbness, tingling, loss of sensation in any part of the body / Other

____

10. PSYCHIATRIC: None / Depression / Nervousness / Anxiety / Mood swings / Other

____

11. ENDOCRINE: None / Excessive thirst or hunger / Heat or cold intolerance / Hot flashes / Other

____

12. HEMATOLOGICAL: None / Easy bruising / Easy bleeding / Anemia / Other

____

Signature: ________________________________ Date: ____________________