ADULT PELVIC HEALTH & CONTINENCE CARE
500 Red Creek Drive, Suite 120, Rochester, NY 14623
T: 585-487-3400 F: 585-334-3327
Dr. Jenifer Byrnes – Dr. Paula Doyle – Dr. Erin Duecy – Pam Wigent Nurse Practitioner

Dear patient,

Welcome to our practice. We understand you have been referred or you have requested an appointment with our Urogynecology Office, at the University Rochester. Our center is a multi-disciplinary practice that includes medical and surgical management of continence and pelvic issues. We understand that having these type of issues impacts you both physically and emotionally, and we therefore approach evaluation and treatment as a team.

APPOINTMENT DATE & TIME: _____ **ARRIVAL TIME**: _____

WITH PROVIDER: Dr. Jenifer Byrnes Dr. Paula Doyle Dr. Erin Duecy

Please bring your packet with you at the arrival time of your scheduled appointment.
DO NOT MAIL IT BACK.

As mentioned on the phone, enclosed is your New Patient Packet. We kindly request that you complete the questionnaire to the best of your ability. The questionnaire has been developed to provide us with important information about your symptoms as well as your overall health. It may seem long, but the more accurate information we have, the better we are able to understand your experience and to help with your treatment.

►►THE DAY OF YOUR VISIT◄◄

- **►Arrive 15 minutes before your scheduled appointment time**.
- **►Please do NOT empty your bladder within 1 hour of your appointment.**
- **►Please bring your insurance card(s) with you for your first visit**.
- **►Be sure to bring your packet with you at the arrival time of your scheduled appointment.**

Insurance - We accept most major insurances in the Rochester area but do not participate with all insurances. Please contact your referring physician and/or insurance company to determine if a referral is required. Your deductible or co-payment fee is determined by your insurance company. We accept exact cash amount, checks, and MasterCard, Visa, and Discover for payment(s) as well.

Late Arrivals/Cancellations – Please arrive **15 mins** before your scheduled appointment time to allow for the check-in and triaging process. If you arrive late for your appointment, you may be rescheduled. We respectfully ask a minimum 24 hour prior notice to cancel an appointment. If you cannot keep an appointment, please notify the office as soon as possible to allow another patient to be seen. Should you not notify us of a cancellation, a $50 charge may be applied. **LATE ARRIVALS MAY RESULT IN RESCHEDULING.**

Directions to our office: A map with written directions is enclosed on the last page (you may rip off the last two pages in packet to keep). PLEASE allow extra time if you are unsure of our location, and feel free to contact us ahead of time if you have any questions about our location.

We look forward to participating in your medical care. Please contact our office if you have any questions or concerns.

STRONG
Memorial Hospital

PLACE PATIENT LABEL HERE

AMBULATORY CARE
INVOLVEMENT IN CARE DISCUSSIONS FORM
(Reference HIPAA Policy 0P23.2)

This is a worksheet to facilitate communication with the patient and with those whom the patient identifies as being involved in their care. It is not meant to replace or be used instead of the SH48 Authorization for Release of Medical Information (required for release of copies of medical records). Those named on the form below are not permitted to access the patient's medical record.

Patient Name: _____ Medical Record #: _____

URMC & Affiliates **University Rochester Urogynecology** (department, provider or practice name) may verbally discuss protected health information, including lab/test results and payment issues with the following people:

NAME	RELATIONSHIP	CONTACT INFO	COMEMENTS

COMMUNICATION REQUESTS

Phone me at this number: (_____) _____ ☐ Yes ☐ No

May phone me at work: (_____) _____ ☐ Yes ☐ No

May leave messages on answering machine ☐ Yes ☐ No

Signature: _____ Date**:** _____
(Please do not sign until you get to your appointment):

This will remain in effect until notified differently by the above patient

NAME _____

PLACE PATIENT LABEL HERE

MEDICATIONS & SUPPLEMENTS:

Please list all medications you are currently taking (including any over-the-counter medications, vitamins, or herbal supplements/home remedies). Include dosage and how often you take it. If you need more room, please list all medications on a separate sheet of paper and attach it to this packet.

Medication Name	Dosage	How Often

Preferred Pharmacy: _____ Phone: _____

Address/Location: _____

ALLERGIES/MEDICATION REACTIONS:

Are you allergic to latex? ❑ no ❑ yes If yes, please list reaction: _____

Please list all medication allergies or reactions below, including the type of reaction experienced. If you need more room, please list all medication and reactions on a separate sheet and attach it to this packet.

Medication Name	Type of Reaction (hives/rash, itching, shortness of breath, nausea, etc.)

PLACE PATIENT LABEL HERE

UROGYNECOLOGY: PATIENT INTAKE FROM

Primary Care MD _____ GYN MD _____

Why are you coming for this evaluation?

☐Urinary leakage with cough/sneeze/exercise ☐Urinary leakage with an urge to urinate
☐Urinary urgency/frequency without leakage ☐Difficulty emptying bladder
☐Pelvic Organ Prolapse/Vaginal bulge ☐Leakage of stool
☐Frequent Bladder Infections ☐Bladder pain/pain with urination
☐Other: _____

MEDICAL HISTORY:

Do you now or have you ever had: (Check yes if you are receiving treatment for the condition.)

☐Diabetes ☐Crohn's Disease/Ulcerative Colitis ☐Glaucoma
☐High blood pressure ☐Blood clot in leg/arm (DVT) ☐Myasthenia Gravis
☐Heart disease ☐Blood clot in lung (PE) ☐Parkinson's Disease
☐Heart attack ☐Asthma ☐ Neurologic Disease
☐Atrial fibrillation ☐COPD/Emphysema ☐ Depression
☐Stroke ☐Seizures/Epilepsy ☐ Fibromyalgia
☐Mini-stroke/TIA ☐Kidney Disease ☐ Irritable bowel syndrome (IBS)
☐Cancer: _____
☐Other: _____

SURGICAL HISTORY:

Have you had any previous surgery for **urinary incontinence**? ☐No ☐Yes, year& type: _____

Have you had any previous surgery for **pelvic organ prolapse**? ☐No ☐Yes, year& type: _____

Have you had a **hysterectomy**? ☐No ☐Yes, year: ____ Type: ☐Abdominal incision ☐Through vagina ☐Laparoscopic

Have you had your **ovaries removed**? ☐No ☐Yes, year: ____

Other surgeries:

Year	Type of Surgery	Surgeon/Hospital	Complication

OB-GYN HISTORY: Number of: Pregnancies _____ Vaginal Deliveries _____ C-Sections _____

SOCIAL HISTORY:

Do you …..	No	Yes	Past Use	Details of past or current use
Smoke or use tobacco?			**Quit date: _____**	**# packs per day: _____ # years of use: _____**
Use recreational drugs?			**Quit date: _____**	**Type: _____ How often? _____**
Drink alcohol?			**Quit date: _____**	**Type: _____ # drinks per week: _____**

FAMILY HISTORY: ❑ check here if you are adopted and/or do not have this information.
Has anyone in your family (blood relative) been diagnosed with any of the following?

Medical Problem	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Father	Mother	Brother	Sister
Breast Cancer								
Colon or Rectal Cancer								
Diabetes								
Endometrial or Uterine Cancer								
Heart Attack								
Heart Disease								
Ovarian Cancer								
Stroke or TIA								
Other: _____								

REVIEW OF SYMPTOMS: Circle and of the following symptoms you are currently experiencing:

Constitutional	fever • chills • weight loss • malaise/fatigue • sweating • weakness
Skin	rash • itching
HENT	hearing loss • ringing in ears • ear pain • ear discharge • nosebleeds • congestion • sinus pain • sore throat
Eyes	blurry vision • double vision • pain with light in eyes • eye pain eye discharge • eye redness
Cardiovascular	chest pain • palpitations • shortness of breath with lying down leg swelling • waking up at night short of breath
Respiratory	cough • coughing up blood • productive cough • shortness of breath wheezing
GI	heartburn • nausea/vomiting • abdominal pain • diarrhea • constipation blood in stool • dark, tarry stools
MSK	muscle pain/aches • neck pain • back pain • joint pain • frequent falls
Endo/Heme/Imm	easy bruising/bleeding • allergies • feeling too thirsty
Neuro	dizziness • headaches •tingling • tremor • change in sensation change in speech • weakness in one arm or leg • seizures passing out/fainting
Psych	depression • suicidal ideas • substance abuse • hallucinations • anxiety insomnia • memory loss

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions on the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a responsive scale from 0 to 4.

Symptom scale:
0 = not present
1 = not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ Prolapse Distress Inventory (POPDI-6)

Do you…	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal Distress Inventory 8 (CRAD-8)

Do you…	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you lose your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Distress Inventory 6 (UDI-6)

Do you…	NO	YES
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

If you have urinary leakage symptoms, please answer these last 2 questions:

1. **How often do you experience urine leakage? (Circle one)**
    1. Less than once a month.
    2. One or several times a month.
    3. One or several times a week.
    4. Every day and or night.
2. **How much urine do you lose each time? (Circle one)**
    1. Drops or little
    2. More

Patient's Bill of Rights

As a patient in a hospital in New York, you have the right, consistent with applicable laws, to:

1. Understand and use these rights. If for any reason they do not understand or they need help, the hospital must provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, gender, gender identity and expression, national origin, disability, sexual orientation, or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if they need it.
5. Be informed of the name and position of the doctor who will be in charge of their care in the hospital.
6. Know the names, positions, and functions of any hospital staff involved in their care and refuse their treatment, examination, or observation.
7. A no smoking room. (SMH is a smoke and tobacco free institution)
8. Receive complete information about their diagnosis, treatment, and prognosis.
9. Receive all the information they need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Receive all the information they need to give informed consent for an order not to resuscitate. They also have the right to designate an individual to give this consent for them if they are too ill to do so. If they would like additional information, a copy of the pamphlet "Do Not Resuscitate Orders – A Guide for Patients and Families" should be provided.
11. Refuse treatment and be told what effect this may have on their health.
12. Refuse to take part in research. In deciding whether or not to participate, they have the right to a full explanation.
13. Privacy while in the hospital and confidentiality of all information and records regarding their care.
14. Participate in all decisions about their treatment and discharge from the hospital. The hospital must provide them with a written discharge plan and written description of how they can appeal their discharge.
15. Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.
16. Review their medical records without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because they cannot afford to pay.
17. Receive an itemized bill and explanation of all charges.
18. View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.
19. You have a right to challenge an unexpected bill through the Independent Dispute Resolution process.
20. Complain without fears of reprisal about the care and services they are receiving and to have the hospital respond to you and, if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to th. The hospital must provide you with the State Health Department telephone number.
21. Authorize those family members and other adults who will be given priority to visit consistent with their ability to receive visitors.
22. Make known their wishes in regard to anatomical gifts. Patients may document their wishes in their health care proxy or on a donor card, available from the hospital.

Patients' Responsibilities

- To the best of their knowledge, provide accurate and complete information about their present symptoms, past illnesses, hospitalizations, medications and other matters relating to their health.
- Provide upon admission a copy of their health care proxy or any other advance directives or power of attorney forms, if they have them.
- Report any changes in their condition or anything that appears unsafe to their nurse or doctor.
- Ask questions if they do not clearly understand the proposed plan of care and what is expected of them.
- Follow the treatment plan that the patient and their doctor have developed. This may include following the instructions of nurses and other health care staff who are involved in their care. Accept the consequences if they do not follow the treatment plan.
- Keep appointments. When they are unable to do so for any reason, notify the office appointment center in advance
- Provide accurate insurance information and promptly pay balances not covered by their insurance.
- Treat other patients and staff with consideration and respect.
- Be considerate of the rights of other patients and the hospital staff by assisting with the control of noise and the number of visitors to the hospital.
- Be respectful of the property of other persons and of the hospital.

Know that the following items and behaviors are not allowed at the hospital or at our clinical office:

Alcoholic beverages Weapons Smoking Street drugs Tobacco

Electronic Cigarettes and emerging tobacco and nicotine product
Disruptive or violent behaviors

If patients are unable to maintain safe and respectful behavior, their activities may be restricted; or, in extreme situation, the hospital may terminate their treatment and offer an alternative plan for care.

Additional Patients' Rights:

You will be free from financial or other exploitation and have access to legal entities for appropriate representation, self-help services and advocacy support services.

If you have questions, suggestions, or concerns or if you need help resolving a problem and would rather not share it with your nurse or another member of your health care team, please call Patient and Family Relations at (585) 275-5418 or send an email to PatientRelationsSMH@urmc.rochester.edu.
If something is bother you, you can talk to us without being afraid that we will be upset with you. You will continue to get excellent care. If you are not satisfied with the response you get from us, you have the right to contact the New York State Health Department. (We can provide that phone number). And if our concerns cannot be resolved through he hospital or Department of Health, you may contact the Joint Commission online at https://www.jointcommission.org/report_a_complaint.aspx .