WillsEye Hospital
America's First World's Best

Shields and Shields, PC
840 Walnut Street, Suite 1440
Philadelphia, PA 19107-5109

我明白如果我有问题或问题，我将联系办公室215-928-3105. 我明白我不会向任何肿瘤服务的医生发送任何电子邮件. 常规电子邮件不符合HIPAA（美国隐私法). 对于医生收到的每封邮件，都将收取40美元的费用.

谢谢你的理解,

管理

我已阅读，理解，我将遵守上述要求

____

家长/法定监护人

I understand that if I have a question or problem, I will contact the office at 215-928-3105. I understand that I will not send any email to any doctor on the Oncology Service. Regular email is not HIPAA compliant (American Privacy Law). For every email a doctor receives, there will be a charge of $40.

Thank you for understanding,

Management

I have read, understand and I will comply with the above requirements

Oncology Service
215-928-3105
215-928-1140- Fax

www.fighteyecancer.com

Eye MDs
Carol L. Shields, MD, Director
Arman Mashayekhi, MD
Sara E. Lally, MD
Jerry A. Shields, MD, Director Emeritus
David Lashinsky, Practice Administrator

New Retinoblastoma Patients With Previous Treatment

Please read over carefully and fill out completely. <u>Incomplete forms may delay treatment</u>.
Provide in **English** the following additional information so that we can better prepare for your upcoming visit:

Child's Name:____ Gender (circle one): Male / Female Date of Birth (month/day/year): ______________

Mother's Name and Contact # and Email:____

Father's Name and Contact # and Email: ____

Treating Physician's Name/Phone/Email/Hospital: ____

What was the reason you first brought your child to see the eye doctor?: ____

What was seen first in patient's eyes? (and by whom): ____

When was your child diagnosed with retinoblastoma?: ____

What treatment has been done so far? (Please state dates, which chemotherapy drugs were used, and the doses). *Bring all photos taken/fundus drawings so we can compare treatment response*:

Does the child have a central line or portacath? (yes/no):_______________

At how many weeks was your child born?:_______________ What was your child's birth weight? (lbs/oz):__________________

Any complications at birth? (yes/no) *Please explain*: ____

Vaginal Birth or Cesarean Section?:_____________________ In Vitro Fertilization or Fertility Treatment? (yes/no): _____________

Are there any other siblings in the family? (Please include half siblings): ____

Is there a family history of retinoblastoma or other eye disorders? (Mother, father, grandparents): ____

Does your child have any medicine or food allergies? *Please describe*:____

Any other medical issues that your child has been diagnosed with?: ____

Is your child currently taking any other medications?: ____

Has your child had an MRI or CT scan done? (yes/no) *If yes, please bring CD of images with you*: _______________ Date of scan:________________________

The following information, if applicable, is <u>required</u> for an appointment. This information may be returned via e-mail: registration@shields.md **or via fax**: 215-928-1140. **<u>ALL</u>** submitted medical information **MUST** be translated into **ENGLISH and received by us before patient's first appointment.**

- Physician Medical Summary, should include: Patient history, and a physicial assessment dated within the last 30 days to detail the patient's current condition
- Laboratory reports
- Surgical reports
- Pathology reports
- Radiology reports
- Chemotherapy administration records
- Radiation therapy records
- Genetic testing reuslts
- Images; specifically fundus photos

Please bring ALL doctor reports, images, MRI or CT scan films or CD with you to your visit. Bring ALL fundus photos taken.

If you decide to be treated here on the Wills Eye Oncology Service, you will be given access to a new patient package which will include and history and physical form. This must be filled out by pediatrician/pediatric oncologist and brought to the office visit. It must be done within 2 weeks of appointment. <u>If you come without it, treatment may be delayed.</u>

Thank You,
The Ocular Oncology Service

Ocular Oncology Service | Wills Eye Hospital
840 Walnut St. Suite 1440 | Philadelphia, PA 19107
(215) 928-3105 | www.fighteyecancer.com

Please check correct box about your childs treatment

treatment	Systemic Intravenous chemotherapy				Intra-arterial chemotherapy (IAC)			Intravitreal Injections		Local	
	Vincristine	Etoposide	Carboplatin	Topotecan	Melphalan	Topotecan	Carboplatin	Melphalan	Topotecan	laser	cryo
date											

If IAC: Do you know the dose?

Melphalan __________ Topotecan __________ Carboplatin __________

If Intravitreal chemotherapy: Do you know the dose?

Melphalan __________ Topotecan __________