WOMEN'S HEALTH INITIATIVE

Form 33 - Medical History Update

MARKING INSTRUCTIONS

- **You may use a pencil or pen (blue or black only).**
- **Darken the circle completely next to the answer you choose.**
- **To change an answer:**
  - **If you are using a pencil, cleanly erase the incorrect mark.**
  - **If you are using a pen, mark an X through the incorrect mark.**
- **Please do not make any stray marks on this form.**

This form asks about any health problems and health care since:

__ __ - __ __ - __ __
Month Day Year

Do not report hospital admissions, medical conditions or tests that happened before this date. However, if you are not sure of the date and don't think that you have reported it to us before, please answer the questions.

Public reporting burden for this collection of information is estimated to average 7 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0414). Do not return the completed form to this address.

OFFICE USE ONLY

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

1. Date Received:
   __ __ - __ __ - __ __ (MM/DD/YY)

2. Reviewed By:
   __ __ - __ __ __

3. Contact Type:
   - ○ 1 Phone
   - ○ 2 Mail
   - ○ 8 Other

4. Visit Type:
   - ○ 3 Annual
   - ○ 4 Non-Routine

○ RCR ○ OU1 ○ OU2

5. Language:
   ● 1 E ○ 2 S

SERIAL #
PLEASE MAKE NO MARKS IN THIS AREA

1. **What is today's date?** (Write the date in the space provided and mark the corresponding bubbles below.)

___ ___-___ ___-___ ___
Month Day Year

Please mark only one bubble per line:

Month ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12

Day ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 ○ 18 ○ 19 ○ 20 ○ 21 ○ 22 ○ 23 ○ 24 ○ 25 ○ 26 ○ 27 ○ 28 ○ 29 ○ 30 ○ 31

Year ○ 15 ○ 16 ○ 17 ○ 18 ○ 19 ○ 20 ○ 21

2. **Who is completing this form?**
   - ○ 1 Self - Women's Health Initiative (WHI) Extension Study participant
   - ○ 8 Other (on behalf of the WHI participant, specify): ______________________________

2.1 Best phone number to reach the person completing this form: (_____) _____ - _______

3. **Since the date on the front of this form,** have you had any of the following exams, tests, or procedures done by a doctor or other health care provider? **Mark all that apply.**
   - ○ 1 Breast exam
   - ○ 2 Mammogram
   - ○ 3 Test of breast tissue or fluid for disease (breast biopsy or aspiration)
   - ○ 4 Other breast examination tests such as MRI or ultrasound
   - ○ 5 Test for the presence of blood in your stool or bowel movement (Hemoccult®, guaiac)
   - ○ 6 Tube inserted into your bowel to check for bowel problems (sigmoidoscopy or colonoscopy)
   - ○ 7 Hysterectomy (surgery to remove the uterus or womb)
   - ○ 8 Biopsy of the endometrium (lining of the uterus or womb)
   - ○ 9 Bone density scan (such as DEXA)
   - ○ 99 **None of the above apply**

Go to the next page →

4. **Since the date on the front of this form,** has a doctor or other health care provider told you that you have any of the following conditions?
Mark all that apply.

- ○ 1 Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis
- ○ 2 Angina or chest pain from a heart condition for which you were hospitalized for one night or more (not a heart attack)
- ○ 3 Transient ischemic attack (not a stroke)
- ○ 4 Osteoarthritis or arthritis associated with aging
- ○ 5 Macular degeneration associated with aging
- ○ 6 Moderate or severe memory problems (dementia or Alzheimer's)
- ○ 7 Parkinson's disease
- ○ 8 Intestine or colon polyps or adenomas
- ○ 9 Systemic lupus erythematosus (lupus)
- ○ 99 **None of the above apply**

5. **Since the date on the front of this form,** has a doctor or other health care provider prescribed any of the following treatments for **diabetes**?
Mark all that apply.

- ○ 1 Insulin
- ○ 2 Pills or medications other than insulin
- ○ 3 Diet and/or physical activity
- ○ 99 **None of the above apply**

6. **Since the date on the front of this form,** has a doctor or other health care provider prescribed for the first time pills for **high blood pressure** or **hypertension**?

○ 0 No ○ 1 Yes

7. **Since the date on the front of this form,** how many times did you fall and land on the floor or ground? Do not include falls due to sports. **Mark only one.**

- ○ 0 None
- ○ 1 One time
- ○ 2 Two times
- ○ 3 Three or more times

Go to the next page →

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

8. **Since the date on the front of this form,** has a doctor or other health care provider told you that you have a new broken, fractured, or crushed bone?

○ 1 Yes ○ 0 No → **If No, go to questions 9–16 on the next page.** →

8.1 Which bone(s) did you break, fracture, or crush?
Mark all that apply.

- ○ 1 Hip or upper leg (also mark in question 10 on the next page)
- ○ 2 Pelvis
- ○ 3 Knee (patella)
- ○ 4 Lower leg or ankle
- ○ 5 Foot (not toe)
- ○ 6 Tailbone (coccyx)
- ○ 7 Spine or back (vertebra)
- ○ 8 Upper arm or shoulder
- ○ 9 Elbow
- ○ 10 Lower arm or wrist
- ○ 11 Hand (not finger)
- ○ 12 Finger or toe
- ○ 13 Jaw, nose, face, and/or skull
- ○ 14 Ribs and/or chest or breast bone
- ○ 88 Other (Specify): ______________________

→ **Go to questions 9–16 on the next page.** →

Questions 9–16

Since the date on the front of this form, have you been hospitalized for one night or more for any reason, **OR** has a doctor or other health care provider diagnosed or treated you for any of the following? **Please answer No or Yes to each item.**

	No	Yes	
9.	○ 0	○ 1	Cancer, malignant growth or tumor (include melanoma, do not include other skin cancers)
10.	○ 0	○ 1	Broken, fractured, or crushed hip or upper leg bone
11.	○ 0	○ 1	Stroke
12.	○ 0	○ 1	Heart disease including heart attack, heart failure, atrial fibrillation (afib), or other heart conditions
13.	○ 0	○ 1	Procedures or surgeries to unblock narrowed blood vessels to your heart or neck such as CABG (heart bypass), PTCA, PCI carotid endarterectomy, angioplasty, or heart stent
14.	○ 0	○ 1	Blood clots in your leg veins or lungs (DVT - deep vein thrombosis or PE - pulmonary embolism)
15.	○ 0	○ 1	Blocked or narrowed arteries to the legs or feet causing poor circulation (not varicose veins)
16.	○ 0	○ 1	Hospitalized for one night or more for any reason

If you answered YES to one or more of the items in questions 9 through 16 above, please go to the next page. →

If you answered NO to all of the items in questions 9 through 16 above, you are done with this form.

Please take a moment to review any questions you may have missed. Feel free to write any comments in the Comments section at the end of the form.

Thank you.

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

Center Perf

Information on New Stroke, Heart, and Circulation Problems

Questions 17–29

Since the date on the front of this form, have you been diagnosed or treated for any of the following conditions or procedures? **Please mark No or Yes to each item.** For each item you mark Yes, also indicate if you were in the hospital for one night or more.

	No	Yes		
17.	○ 0	○ 1	Stroke	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
18.	○ 0	○ 1	MI, heart attack (coronary, myocardial infarction)	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
19.	○ 0	○ 1	Heart failure (congestive heart failure, CHF or HF)	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
20.	○ 0	○ 1	Heart bypass operation (coronary bypass surgery or CABG)	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
21.	○ 0	○ 1	Heart valve problem or surgery to repair or replace a heart valve	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
22.	○ 0	○ 1	Atrial fibrillation, atrial flutter, or irregular heartbeat, requiring medications OR a procedure (such as electrical shock, cardioversion, ablation, or surgery)	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
23.	○ 0	○ 1	Abdominal aortic aneurysm (AAA) requiring surgery or stent	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
24.	○ 0	○ 1	Blood clots in your lungs (pulmonary embolism or PE)	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes
25.	○ 0	○ 1	Blood clots in the veins of your legs (deep vein thrombosis or DVT)	
			If Yes, were you in the hospital for 1 night or more?	○ 0 No ○ 1 Yes

Continue on the next page →

Information on New Stroke, Heart, and Circulation Problems, continued

	No	Yes	
26.	○ 0	○ 1	Procedure to unblock narrowed blood vessels to your heart (opening the arteries of the heart with a stent, balloon, laser, or other device). Also called PTCA, angioplasty, or percutaneous coronary intervention (PCI).
			If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
27.	○ 0	○ 1	Procedure or surgery to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)
			If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
28.	○ 0	○ 1	Poor blood circulation or any procedure to unblock narrowed arteries to your legs or feet (claudication, peripheral arterial disease, PAD, or gangrene). Do not include varicose veins.
			If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
29.	○ 0	○ 1	Other heart or circulation conditions (Specify):______________________
			If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes

Complete the health care provider information for the heart or circulation items you marked Yes in questions 17–29.

30. **1st Hospital or MD office** where you were diagnosed, treated, or admitted.

Name: ____

____
Street City State

31. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): ___ ___-___ ___-___ ___
Month Day Year

32. How many nights were you in the hospital? ___ ___ Nights (write "0" if no nights)

Go to the next page →

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

Information on New Stroke, Heart, and Circulation Problems, continued

33. 2nd Hospital or MD office where you were diagnosed, treated, or admitted.

Name: ______________________________

____
Street City State

34. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): __ __-__ __-__ __
Month Day Year

35. How many nights were you in the hospital? __ __ Nights (write "0" if no nights)

36. 3rd Hospital or MD office where you were diagnosed, treated, or admitted.

Name: ______________________________

____
Street City State

37. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): __ __-__ __-__ __
Month Day Year

38. How many nights were you in the hospital? __ __ Nights (write "0" if no nights)

39. 4th Hospital or MD office where you were diagnosed, treated, or admitted.

Name: ______________________________

____
Street City State

40. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): __ __-__ __-__ __
Month Day Year

41. How many nights were you in the hospital? __ __ Nights (write "0" if no nights)

42. Did you have more than four hospital stays for stroke, heart, or circulation conditions?

○ 1 Yes ○ 0 No → **If No, go to the next page.**

42.1 How many other hospital stays? ○ 1 One stay ○ 2 Two stays ○ 3 Three stays or more

Record additional provider information in the Comments section at the end of this form, then continue to the next page.

 Go to the next page →

Questions on New Broken, Fractured, or Crushed Bone

43. **Since the date on the front of this form,** has a doctor or other health care provider told you that you have a new broken, fractured, or crushed hip or upper leg bone?

○ 1 Yes ○ 0 No → **If No, go to the next page** →

43.1 Which bone(s) did you break, fracture, or crush? **Mark all that apply.**

○ 1 Hip

○ 2 Upper leg (not hip)

43.2 Was this broken, fractured, or crushed hip or upper leg bone first diagnosed or treated during a hospital stay?

○ 1 Yes ○ 0 No → **If No, go to question 43.6 below.**

43.3 In what hospital or medical facility were you diagnosed or treated for the broken, fractured, or crushed hip or upper leg bone?

Name: ______________________________

____
Street City State

43.4 Date you entered the hospital (estimate if unsure): __ __-__ __-__ __
Month Day Year

43.5 Did you stay overnight? ○ 0 No ○ 1 Yes

43.6 Was an outpatient X-ray or imaging scan (CT or MRI) taken to diagnose the broken, fractured, or crushed hip or upper leg bone at a facility not reported above?

○ 1 Yes ○ 0 No → **If No, go to the next page** →

43.7 In what hospital or medical facility were you diagnosed or treated for the broken, fractured, or crushed hip or upper leg bone?

Name: ______________________________

____
Street City State

43.8 Date of X-ray or other imaging scan (CT or MRI) (estimate if unsure): __ __-__ __-__ __
Month Day Year

Center Perf

Questions on New Cancer, Malignant Growth, or Tumor

44. **Since the date on the front of this form,** has a doctor or other health care provider told you that you have a new cancer, malignant growth, or tumor? Do not include benign tumors.

○ 1 Yes ○ 0 No → **If No, skip to question 46 on page 13.** →

44.1 Which cancers, malignant growths, or tumors were you told you had? **Mark all that apply.**

- ○ 1 Breast
- ○ 2 Ovary
- ○ 3 Endometrium (lining of the uterus or womb)
- ○ 4 Cervix
- ○ 5 Other female genital organs (not ovary, endometrium, or cervix)
- ○ 6 Colon or rectum
- ○ 7 Bladder or urinary tract
- ○ 8 Brain
- ○ 9 Esophagus
- ○ 10 Gallbladder or bile ducts
- ○ 11 Hodgkin's Lymphoma
- ○ 12 Non-Hodgkin's Lymphoma
- ○ 13 Kidney
- ○ 14 Leukemia
- ○ 15 Liver
- ○ 16 Lung
- ○ 17 Melanoma
- ○ 18 Multiple myeloma
- ○ 19 Pancreas
- ○ 20 Skin cancer **(not melanoma)**
- ○ 21 Stomach
- ○ 22 Thyroid
- ○ 88 Other or unknown cancer **(Specify):**

____

____

____

Go to the next page →

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

Questions on New Cancer, Malignant Growth, or Tumor, continued

Please provide information for the doctor or other health care provider who diagnosed the cancer. If you have been diagnosed with more than one cancer since the date on the front of this form, write the provider information below for the **first cancer**.

Diagnosis Information for the First Cancer since the date on the front of this form

44.2 When was this cancer diagnosed (estimate if unsure)? ___ ___-___ ___-___ ___
Month Day Year

44.3 Who was the doctor or other health care provider who diagnosed this cancer?

Doctor or provider name: ______________________________

____
Street City State

44.4 At what facility was this cancer first diagnosed?

Place name: ______________________________

____
Street City State

44.5 Was this cancer diagnosed during an overnight hospital stay?

○ 1 Yes ○ 0 No

44.6 Date you were admitted (estimate if unsure): ___ ___-___ ___-___ ___
Month Day Year

44.7 Was an outpatient X-ray or imaging scan (CT, MRI, mammogram, bone or PET scan) taken to diagnose the cancer at a place other than what you reported above?

○ 1 Yes ○ 0 No → **If No, go to the next page.** →

44.8 Place name: ______________________________

____
Street City State

44.9 Date of X-ray or scan (estimate if unsure): ___ ___-___ ___-___ ___
Month Day Year

Go to the next page →

Questions on New Cancers, Malignant Growths or Tumors, continued

Cancer-related Surgeries for the First Cancer

45. **Since the date on the front of this form,** have you had any cancer-related surgeries following the diagnosis of the first cancer?

○ 1 Yes ○ 0 No →

45.1 If No, are any planned?

○ 1 Yes
○ 0 No

→ **Go to the next page** →

Since the date on the front of this form:

45.2 Number of cancer-related surgeries you had: __ __

45.3 Type(s) of cancer-related surgery **(Specify):** ______________________

45.4 At what facility was this first cancer-related surgery done?

Place name: ______________________

____

Street City State

45.5 Date of first cancer-related surgery (estimate if unsure): __ __-__ __-__ __
Month Day Year

45.6 Was this cancer treated during an overnight hospital stay?

○ 1 Yes ○ 0 No → **If No, go to the next page.** →

45.7 How many nights were you in the hospital? __ __ Nights (write "0" if no nights)

Record the provider information for any additional cancers in the Comments section at the end of this form, then continue to the next page.

Go to the next page →

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

Information on Hospital Stays (not already reported on this form)

46. **Since the date on the front of this form,** have you been admitted to a hospital for one night or more for any of the following? **Do not include an overnight stay that you have already reported on this form.**

- Appendectomy or removal of appendix; bowel or intestinal obstruction (not cancer); gallbladder attack or gallbladder surgery; hernia repair
- Back surgery such as laminectomy or spinal fusion
- Fracture (not hip or upper leg)
- Joint repair or replacement
- Surgery for vaginal, uterine, or rectal prolapse; bladder suspension; stress incontinence

○ 1 Yes ○ 0 No

47. **Since the date on the front of this form,** have you been admitted to a hospital for one night or more for any other reason? **Do not include an overnight stay that you have already reported on this form.**

○ 1 Yes ○ 0 No → **If No, go to Final Instructions at the end of the next page.** →

Please give the details of your first two hospital stay(s) not already reported on this form.

47.1 **1st hospital stay** of one night or more.

Hospital name: ______________________________

____
Street City State

47.2 Date you entered the hospital (estimate if unsure): __ __-__ __-__ __
Month Day Year

47.3 How many nights were you in the hospital? ○ 1 One ○ 2 Two or more

47.4 Reason for this hospital stay **(Specify)**: ______________________________

____

Go to the next page →

Information on Hospital Stays, continued (not already reported on this form)

47.5 **2nd hospital stay** of one night or more.

Hospital name: ______________________________

____
Street City State

47.6 Date you entered the hospital (estimate if unsure): __ __-__ __-__ __
Month Day Year

47.7 How many nights were you in the hospital?

○ 1 One ○ 2 Two or more

47.8 Reason for this hospital stay **(Specify)**: ______________________________

____

48. **Did you have any other hospital stays** not yet reported?

○ 1 Yes ○ 0 No → **If No, go to Final Instructions below.**

48.1 How many additional hospital stays did you have?

○ 1 One ○ 2 Two ○ 3 Three or more

Record the additional provider information in the Comments section at the end of the form, then continue to the Final Instructions below.

Final Instructions

Please read, then sign and date the Authorization to Release Medical Records on the next page. By signing this form you are giving permission for your provider to release a copy of your medical records to WHI.

You may receive a follow-up call to clarify your answers on this form.

Please take a moment to review any questions you may have missed. Feel free to write any comments in the Comments section at the end of the form.

Go to the next page →

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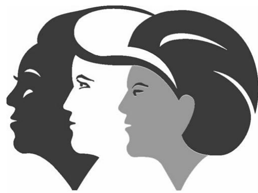
SERIAL #



Release records to:
Women's Health Initiative

NE Regional Center Sites

- ☐ University at Buffalo
  65 Farber Hall
  Buffalo, NY 14214
  716-829-3128, 855-944-2255
- ☐ WHI Brigham & Women's Hospital
  Division of Preventive Medicine
  900 Commonwealth Ave E, Floor 3
  Boston, MA 02215
  617-278-0791, 800-510-4858
- ☐ MedStar Research Institute
  Please contact the Buffalo Regional Center at the numbers provided.

SE Regional Center Sites

- ☐ Wake Forest School of Medicine
  PHS-SSHP, WHI
  Bldg 90 South, 3rd FL
  PO Box 573152
  Winston Salem, NC 27157
  336-713-4221, 877-736-4962
- ☐ University of Florida
  1600 SW Archer Rd.
  PO Box 100277
  Dental Tower; Rm D8-26
  Gainesville, FL 32610
  352-294-5211, 800-944-4594

Midwest Regional Center Sites

- ☐ OSU at Wexner Medical Center
  1581 Dodd Dr., Suite 140
  Columbus, OH 43210
  614-688-3563, 800-251-1175
- ☐ University of Pittsburgh
  130 N Bellefield Ave., Rm 550
  Pittsburgh, PA 15213
  800-552-8140
- ☐ The University of Iowa
  411 Laurel St., Suite 3262
  Des Moines, IA 50314
  515-643-4840, Fax: 515-643-4841

Western Regional Center Sites

- ☐ Stanford University
  1070 Arastradero Road
  Suite 100, WHI
  Palo Alto, CA 94304-1334
  888-729-8442
- ☐ The University of Arizona
  Amelia Lobos, WHI
  3950 S Country Club Rd. #330
  Tucson, AZ 85714
  520-626-5487, 800-341-7672

Clinical Coordinating Center

- ☐ Fred Hutch (WHI)—M3-A410
  1100 Fairview Avenue N
  Seattle, WA 98109
  800-514-0325

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(Protected Health Information)

(WHI OFFICE USE ONLY) Release records from:

The Women's Health Initiative (WHI) Extension Study is a national study sponsored by the National Institutes of Health (NIH) whose ongoing purpose is to learn about the health of post-menopausal women. By signing this form, I give permission to these facilities to give information about my health care and health conditions to: the investigators at the WHI Clinical Coordinating Center (CCC) and the Regional Center affiliates.

The information released will only be used for research purposes by the WHI and will be held in strict confidence. Examples of medical information to be requested:

Discharge summary	Operative reports	Consultations
History and physical	Procedure reports	Outpatient/short stay records
Radiology/imaging	Lab tests and results	
Pathology reports/ specimens	Diagnostic/ procedure codes	MD notes/ progress notes
ER records	Other:	

By signing, I acknowledge that I have read and understood the following:

- Signing this authorization is voluntary.
- Although not being asked by WHI, information released may include all aspects of treatment, including testing and/or treatment of sexually transmitted diseases, AIDS or HIV infection, alcohol and/or drug abuse, and mental health conditions.
- I have the right to revoke (cancel) this authorization at any time by notifying the WHI and the facility in writing. If I do this, it will be in effect immediately as soon as it is received and no further information about my health care and health conditions will be requested. If I revoke this authorization, it will not affect information already released and will not affect my enrollment or participation in WHI or my treatment, payment, enrollment, or eligibility for benefits at this facility.
- The above medical records may be shared with researchers at the WHI CCC at the Fred Hutchinson Cancer Research Center, WHI

Regional Centers and their affiliates, the NIH (study sponsor), and regulatory agencies and review boards who watch over the safety, effectiveness and conduct of the research. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule but the WHI, as a nationally funded research study, has established continued protection for the disclosed information.

- WHI **cannot** further use or disclose the information in my medical records without my consent unless required by law.
- This authorization shall remain valid for the duration of the WHI Extension Study.
- I have the right to receive a copy of this authorization.
- A photocopy or facsimile of this document is as valid as the original.

I give permission for any and all facilities and providers to release my health information.

____
Signature of WHI Participant
(or Authorized Representative)

Today's Date: __ __ - __ __ - 20 __ __
Month Day Year

____
Printed Name of WHI Participant
(or Authorized Representative and relationship to participant)

Participant's Date of Birth: __ __ - __ __ - 19 __ __
Month Day Year

Phone #: (_____) _____ - ________

Comments

Please report comments/additional provider information below. Provider information includes: Hospital/physician name; city and state; date of admission; length of stay, and reason for stay

____

____

____

____

____

____

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PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

SCANTRON. OpScan iNSIGHT™ EM-257848-19:654321