

Registration

© 010211 Norton A. Roitman, MD
filled out by applicant, parent, guardian or completed by assistant

Applicant _____ age _____ sex _____ birth date _____

address _____ city, state, zip _____

phones: home _____ work _____ cell _____ email _____

best time to call at home _____ work _____ days off (circle) Su M T W Th F S

check your preferences: any contact is fine do not call at home; do not call at work; do not leave messages; do not fax

employer/school _____ job/grade _____

street address _____ city, state, zip _____

referred by _____ personal physician _____

Primary contact _____ relationship _____

address check if same as above: _____ city, state, zip _____

phones: home _____ work _____ cell _____ email _____

best time to call at home _____ work _____ days off (circle) Su M T W Th F S

check your preferences: any contact is fine do not call at home; do not call at work; do not leave messages; do not fax

employer/school _____ job/grade _____

street address _____ city, state, zip _____

Secondary contact _____ relationship _____

address check if same as above: _____ city, state, zip _____

phones: home _____ work _____ cell _____ email _____

best time to call at home _____ work _____ days off (circle) Su M T W Th F S

check your preferences: any contact is fine do not call at home; do not call at work; do not leave messages; do not fax

employer/school _____ job/grade _____

street address _____ city, state, zip _____

I request initial consultative services for myself, my family, my client and/or my dependent.

If applying for a minor, I certify that I have the legal right to obtain of consultation, evaluation and/or treatment.

Permission for services and release of information can be revoked at any time.

I understand that this initial consultation does not initiate a doctor/patient relationship and may result in a referral, report, discharge or consultation with a third party.

I understand that I am responsible for the charges incurred for these services unless a specific payor (person, third party or agency) arranged for payment in advance.

Please specify payor: myself _____.

Responsible party _____ date _____

Applicant _____ Age _____ Date of Evaluation _____

Filled out by parent other _____ clinician _____

Use the lines below each section or the back of the page to explain your answers. Although some questions may be difficult to answer in the space provided, do your best to be brief and to the point. During the interview you can ask questions, explain your answers, discuss whatever you like.

This interview is used for children of all ages. For questions that are not appropriate for her age, just write in NA.

1. What is the purpose of her evaluation? What problems do you think she has?

Problem list: _____

2. When did these problems start? _____ How long do you think it will take to take care of them? _____

3. What do you think caused them? _____

Treatment

4. Did she have counseling for ADD/ADHD, emotional or behavioral problems? yes no

Age	Where	Who treated her	What for	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Did she take medication in the past? yes no (List current medications on page 4, past meds below)

If so	What kind	What for	How much/how often	Doctor	She took it for (how long)	Until when
Example:	Ritalin	concentration/attention	15 mgs/ 2 times a day	Jones	2 years	until 6 month ago
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

6. Was she hospitalized for these or other problems? yes no If so, how many times? _____

Age	Where	His doctor	What for (diagnosis, if any)	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Did she have any BAD REACTIONS to medications? no yes _____

Was treatment helpful? yes no sort of Explain: _____

7. Placements Other than treatment centers, list the places she lived when she did not stay with her mother or father.

age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____

Growing up

8. Did she have any MEDICAL problems at birth birth to age 3 3 to 5 5 to 12 12 to 18? no

Please explain: (put recent and current conditions on page 4) _____

9. Did she have DELAYS or problems with: don't know

- crawling/walking coordination eating _____
 ear infections growing weaning _____
 learning to talk toileting attention _____
 staying alone playing learning _____

10. What words fit her PERSONALITY best: social leader loner joiner fearful temperamental self-absorbed
 shy careful serious scattered fighter withdrawn impulsive aggressive thoughtless gothic stoner
 rigid fearless angry fun easy going defiant weird studious other _____

11. Did she have trouble GETTING ALONG _____ no

with other kids brothers/sisters parents _____

teachers other authority figures? _____

starting in preschool KG grade _____

Any past trouble with the law? no yes _____

vandalism/theft fires drugs truant _____

hurt animals gang activity violence _____

12. Did she WORRY about leaving home going to school safety/heath being around people? no

When worried, did she have stomach pains trouble sleeping nightmares panic attacks? Other: _____ no

Did she ever try to harm herself? Explain: _____ no

13. Did she undergo TRAUMA such as DEATHS, illness or losses parents DIVORCED witness ABUSE? no

Was she abused, mistreated or abandoned? yes no Explain this section below

How was she PUNISHED? NA _____

timed out grounded points _____

natural consequences belted _____

lectured chores other _____

Was she poorly accepted or _____

rejected by her parents _____

raised by foster parents? _____

Did her parents lose control? _____

Did either use drugs or alcohol? _____

Were they in trouble with the law? _____

Everyday life

14. School _____ none. What grade is she in? _____ What grade should she be in? _____

Learning disability NA yes: reading math written language verbal receptive expressive processing speech Other _____

Special classes: none resource self-contained other: _____ Was she RPC'd Suspended Expelled Special schooled: _____

Give some idea of her range of GRADES last year As Bs Cs Ds Fs. Is this different than before? yes no
When did this change? _____ Why? _____

15. Does she do chores or work NA? yes no What does she do? _____

16. Does she follow any religion or spiritual practice? _____ none

17. Problems and stress. Check all areas of concern.

- | | | | | | | | |
|---------------------------------------|---|--|---|---|---|--|--------------------------------|
| <input type="checkbox"/> PERSONAL | <input type="checkbox"/> self-control | <input type="checkbox"/> motivation | <input type="checkbox"/> concentration | <input type="checkbox"/> fatigue | <input type="checkbox"/> mood | <input type="checkbox"/> organization | <input type="checkbox"/> grief |
| | <input type="checkbox"/> family illness | <input type="checkbox"/> health | <input type="checkbox"/> accident | <input type="checkbox"/> adoption | <input type="checkbox"/> parenting | <input type="checkbox"/> home/household/move(s) | |
| <input type="checkbox"/> RELATIONSHIP | <input type="checkbox"/> friend(s) | <input type="checkbox"/> roommate | <input type="checkbox"/> girl/boyfriend | <input type="checkbox"/> coach/tutor | <input type="checkbox"/> teacher | <input type="checkbox"/> plays with younger kids | |
| <input type="checkbox"/> FAMILY | <input type="checkbox"/> fighting | <input type="checkbox"/> conflicts/divorce | <input type="checkbox"/> custody | <input type="checkbox"/> sibling problems | <input type="checkbox"/> parents | <input type="checkbox"/> other relatives | |
| <input type="checkbox"/> SCHOOL | <input type="checkbox"/> performance | <input type="checkbox"/> concentration | <input type="checkbox"/> behavioral | <input type="checkbox"/> disability | <input type="checkbox"/> accommodation | <input type="checkbox"/> conflicts | |
| <input type="checkbox"/> HABIT | <input type="checkbox"/> alcohol/drug | <input type="checkbox"/> gambling | <input type="checkbox"/> sexual | <input type="checkbox"/> obsession | <input type="checkbox"/> impulsivity | <input type="checkbox"/> other behavioral | |
| <input type="checkbox"/> LEGAL | <input type="checkbox"/> probation | <input type="checkbox"/> parental fitness | <input type="checkbox"/> competency | <input type="checkbox"/> drug/alcohol | <input type="checkbox"/> community safety | <input type="checkbox"/> criminal allegation | |

18. Explain how she copes with stress:

How well do you think she is doing? poorly could be better varies very well in denial

19. What are her strengths and interests? reading writing music (what kind) _____ play sports (which one) _____

faith/prayer community/church building/mechanics/computer chores shopping collections video/computer games plays instrument

movies/TV art/photo travel friends/social blogs/chat/online gamble journal design /fashion coach/volunteer other: _____

Family

20. Did she go through divorce? yes no Was it difficult? yes no Is it still? yes no

Are/were there problems with legal custody physical custody visitation alimony/child support parental differences abuse allegations

Explain: _____

21. Have any of her blood relatives had EMOTIONAL, BEHAVIORAL or ADDICTION problems? yes no

addiction drugs alcohol learning disability ADHD Manic depression/bipolar depression anxiety panic autism

obsessive/compulsions psychosis/schizophrenia diagnosis unknown needed medication hospitalized other: _____

22. List her family members living in her home(s). Use an "[s]" in the box to indicate step-relative.

Example SUSAN SAMPLER . age 15 . mom dad sister brother other _____ ---> Lives with her other home her father

Name _____ . age ____ . mom dad sister brother _____ ---> Lives w/her other home _____

Name _____ . age ____ . mom dad sister brother _____ ---> Lives w/her other home _____

Name _____ . age ____ . mom dad sister brother _____ ---> Lives w/her other home _____

Name _____ . age ____ . mom dad sister brother _____ ---> Lives w/her other home _____

Name _____ . age ____ . mom dad sister brother _____ ---> Lives w/her other home _____

Name _____ . age ____ . mom dad sister brother _____ ---> Lives w/her other home _____

Her visitation schedule is NA: _____

Health

23. Past and current MEDICAL PROBLEMS. Write in her age (approximate) when she was first diagnosed with:

Medical condition(s) and/or check below _____ no medical problems
 _____ asthma/emphysema/lung disease _____ genital _____ Tourette's/other tics _____ self-injury
 _____ serious injury to arms, legs, back _____ thyroid/pituitary/hormone _____ chronic fatigue _____ wetting/soiling
 _____ blood pressure/anemia/valve _____ urinary/bladder _____ skin cancer/disease _____ other cancer
 _____ ulcers/colitis/rectal/colon/esophagus _____ prostate cancer/disease _____ shaking _____ AIDS/HIV/STD
 _____ jaundice/hepatitis/liver disease _____ heart attack/heart disease _____ paralysis/sensory _____ kidney/renal
 _____ black-outs/epilepsy/seizures _____ head injury/stroke/migraine _____ infectious disease _____ diabetes
 _____ eyes/ears/nose/throat _____ lymphoma/leukemia/blood _____ arthritis _____ ear infections

Is your daughter having monthly periods? NA yes no Using contraception? yes no Could she be pregnant? yes no

24. Check any persistent or bothersome symptoms:

back problems headaches allergies bed wetting/soiling stomach aches nausea vomiting diarrhea
 bloody/black stools unusual weight gain or loss bladder control leg swelling excessive coughing or coughing blood
 chest pain wheezing fatigue joint pain muscular pain visual problems changes in sexual behavior sleeping
 rash/abnormal itching persistent fever shortness of breath drug problems Other _____

Last physical exam by doctor _____ Month/year _____

25. List below major accidents:

Date	Type of Injury	Location of accident	case pending?
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

26. Did she ever have an EKG (heart monitor)? yes no Was it abnormal? yes no

27. Did she have a head injury, an EEG (brain wave test) or seen a neurologist (brain specialist)? yes no

28. List the medications she is allergic to: penicillin sulfa others _____

29. Does she have a poor DIET? yes In what way? _____ no

30. CAFFEINATED beverages (energy drinks, colas, tea, coffee) each day? _____ Tobacco NA chew smoke _____

31. On average, how many cigarette packs does she smoke for how many years? NA quit _____ packs/day _____ years

32. **CURRENT MEDICATIONS** and TREATMENTS she is taking still. Also list herbal remedies and supplements.

What kind	What for	How much/how often	Prescribing doctor	How long
Example: DOXYCYCLINE	acne	100 mgs/ twice a day	Dr. Smith	1 year
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Drug and Alcohol Profile

Check here if this section is Not Applicable

Has anyone told her they were concerned about her drug or alcohol use? yes no
 Does it annoy her when others tell her how they feel about her drinking or use? yes no
 Has she ever felt guilty about drinking? yes no
 Did she ever drink to get the day started when she first woke up (had an eye-opener)? yes no

Has she ever: had a seizure while withdrawing from alcohol or drugs? yes no
 hallucinated, had shakes, anxiety, agitation or physical craving after stopping? yes no
 gone to two or more, or switched doctors to get more prescriptions? yes no

Has she ever lost memory due to alcohol or drugs? temporarily permanently Ever blacked out?
 Ever overdose on purpose? by accident? go to the hospital? stomach pumped? admitted overnight?
 If she no longer drink or use drugs, why did she stop? _____

Ever go to AA NA CA ACOA Al-anon Ever have a sponsor? Is she familiar with the 12 steps?

Check all the substances she has tried and circle her favorites.

When did she start?

	Age	How much and how often do/did she use? Cost per week.	Did she stop?	When
<input checked="" type="checkbox"/> EXAMPLE (weed)	10	One or two blunts every day. \$50 to \$300 per week	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	2 months ago
<input type="checkbox"/> alcohol	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> weed/marijuana	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> crystal meth/speed	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> cocaine/ crack	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> XTC/ecstasy/MDMA/X	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> heroin	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> mushrooms/peyote	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> LSD/ PCP	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> GHB/ DXM/ K	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> sherm	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> Xanax/Valium/Ativan	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> barbiturates	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other prescriptions	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> huffing paint, glue, etc.	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other _____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> I mixed them as follows _____				

Did she get into legal or other trouble in any way due to her substance use? Please explain:

List any other addiction she might have. _____

CHILD Psych Symptoms Checklist –(Girl)

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Daughter's Name _____

Date _____

Filled out by _____

Relationship _____

This questionnaire defines your daughter's problem areas. Many of these questions may not apply. Some may sound strange or be inappropriate but please do your best. You can ask questions and explain your answers during the interview.

Check NOW, PAST, or N/A (Not Applicable/appropriate) for each line as it applies to your daughter NOW, in the past only, both or neither.

For example:

NOW PAST N/A

- Does your daughter like to watch television?
 Does your daughter drive carefully?
 Does your daughter have allergies?
 Does your daughter wet her bed?

If your daughter has DEPRESSION, please describe what it is like for her: (If not, check here, and move on to page 2)

NOW PAST N/A

- Does her depression or sadness COME AND GO frequently?
 Do her moods come OUT of the BLUE?
 Is her depression triggered by things that HAPPEN?
 Does she stay depressed for 2 WEEKS or more with little if any relief?

When she is depressed, does she:

NOW PAST N/A

- ... lose her ENERGY?
 ... have a "WHATEVER" attitude *only* when she is depressed?
 ... lose INTEREST in everything? ... slow down ... become RESTLESS?
 ... lose her APPETITE? ... LOSE weight ... GAIN weight?

 Does she have trouble FALLING ASLEEP?
 ... wake up in the MIDDLE of the night, or EARLY in the morning? wake up IN A PANIC?
 ... need a lot of NAP TIME?
 Does your daughter wake GASPING for breath? SNORE?

During periods of depression, does your daughter:

NOW PAST N/A

- ... get very ANGRY AT HERSELF? ... all the time? ... only when very depressed?
 ... feel GUILTY for things that are not her fault?
 ... STAY ALONE ... MOPE around?
 ... have trouble THINKING or CONCENTRATING?
 ... CRY easily ... seem DESPERATE?

If your **daughter** has thoughts about hurting herself:

NOW PAST N/A

- Do you have reason to believe she has INJURED HERSELF on purpose?
 Do you think she has THOUGHTS about taking her life?
 Do you think that she has PLANS to do it?
 Has she ever TRIED to end her life?

Do you think she has any such thoughts or plans NOW?

CHILD Psych Symptoms Checklist –(Girl)

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Is your daughter ever ON EDGE (anxiety or panic) to an extreme? (If not, check [] here, and move on to the next section.)

NOW PAST N/A

- Do her nerves effect EVERY PART of her life?
- Does she have sudden ATTACKS ...[] MINUTES or ... [] HOURS that go away quickly?
- ...does she stay nervous for a ...[] FEW DAYS, or ... is it [] ALWAYS THERE?
- Does your daughter complain about FEELINGS IN HER BODY when she gets upset, such as...
- PAINS in her ...[] CHEST, ...[] HEAD or ...[] STOMACH?
- When nervous, does your daughter have trouble BREATHING?
- complain that her ...[] HEART POUNDS? ...[] LOSES FEELING in her hands, head or feet?
- Does your daughter look SHAKY, SWEATY, FLUSHED or DIZZY when she gets nervous?
- Does your daughter AVOID PEOPLE or ...[] THINGS? _____
- Does she have extreme NIGHTMARES? For instance
- Does she talk about memories that are so real, it's like she is actually LIVING them?
- Does she ever seem to be OUT OF TOUCH like she is OUTSIDE OF HER BODY as though she is watching a movie of her life instead of living it?

Does your daughter have abnormal MOVEMENTS of her face or other parts of her body?

(If not, check [] here, and move on to the next section below.)

NOW PAST N/A

- Does she get movements or irritations in her THROAT or MOUTH such as throat clearing or sniffing?
- Do her hands SHAKE a lot of the time?
- Do other parts of your her body JERK uncontrollably?
- Does this happen only when she is nervous?
- Does it happen at BEDTIME when she is trying to fall asleep?
- Does your daughter call out FOUL LANGUAGE out of the blue as though she has no control?
- Does your daughter have severe HEADACHES?
- Has she ever ...[] BLACKED-OUT ... [] had FITS ... [] FAINTED ... [] SEIZURE(S)?
- Has your daughter WET or SOILED her clothes? ... [] DURING BLACKOUTS?

Does your daughter have:

NOW PAST N/A

- THOUGHTS that just WON'T GO AWAY?
- ... the need to DO THINGS OVER AND OVER almost unable to stop?
- ... uncontrollable urges such as CHECKING her body, locking the door over and over again, washing, counting, or having to have everything ... [] "JUST SO"?
- If your daughter tries to control these, does it seem to be extremely UNCOMFORTABLE for her?

Does your daughter take things very SERIOUSLY to the point that she performs:

- RITUALS, ROUTINES or HABITS that don't make sense?
- Would you or others describe your daughter as RIGID?
- Do you ever think that your daughter's "trying to be PERFECT" gets out of hand?

Does your daughter

NOW PAST N/A

- BINGE eat or PURGE food?
- Use LAXATIVES or make herself VOMIT?
- Does your daughter think he or she is over-weight whiles others see her as just fine?

CHILD Psych Symptoms Checklist –(Girl)

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Has she done things OUT OF CHARACTER such as:

NOW PAST N/A

- Gone SEVERAL NIGHTS WITH LITTLE IF ANY SLEEP?
 SPENT a lot? ... GAVE away THINGS she treasured?
 Shown a lot of ... ENERGY? Acted exceptionally ... STRONG or... SMART?
 Treated OTHERS POORLY, acted RUDE, HOSTILE or ARGUMENTATIVE out of character?
 Did your daughter feel SHAME or regret LATER about unusual things she did?
 Has her SEXUAL DRIVE or behavior ever been a concern to you?
 Does she get very, very focused on HORROR films, PAIN or REVENGE?
 Did your daughter show signs of EXTREME JEALOUSY?
 Do these characteristics come and go together in episodes?
 Are they part of her EVERYDAY behavior?
 Do you think these out of character reactions are due only to drug use?
 Is your daughter showing these characteristics now?

Did your daughter ever say that BIZARRE things were happening, such as:

NOW PAST N/A

- VOICES whispering, talking, calling her name or swearing at her?
 SMELLING things no one else does?
 ... heard or saw THINGS or PEOPLE that no one else does?
 ... lost her sense of DIRECTION ... MEMORY?
 Has your daughter ever said that things looked like they were breathing, shrinking or growing?

Has she:

NOW PAST N/A

- stopped TAKING CARE of herself?
 become ill at ease WITH PEOPLE?
 ... lost her SENSE OF HUMOR?
 ... said that the RADIO or T.V. was TALKING to her?
 ... said her THOUGHTS WERE BEING READ or CONTROLLED?
 Does she have thoughts or beliefs that are IRRATIONAL and hard to follow, understand or believe
(aside from those other kids her age might have)?
 Do you think ALCOHOL or DRUGS were responsible for these reactions?

Would you use any of the following terms to describe your daughter's USUAL behavior?

- | | | | | |
|----------------------------------|-------------------------------------|---|---|--|
| <input type="checkbox"/> Selfish | <input type="checkbox"/> Steals | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Hurts animals |
| <input type="checkbox"/> Fidgety | <input type="checkbox"/> Sets fires | <input type="checkbox"/> Destructive | <input type="checkbox"/> Anti-authority | <input type="checkbox"/> Lacks conscience |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Fights | <input type="checkbox"/> Restless | <input type="checkbox"/> Distractible | <input type="checkbox"/> Insensitive to pain |
| <input type="checkbox"/> Willful | <input type="checkbox"/> Argues | <input type="checkbox"/> Irresponsible | <input type="checkbox"/> Calls out in class | <input type="checkbox"/> Can't wait turn |
| <input type="checkbox"/> Bullies | <input type="checkbox"/> Cheats | <input type="checkbox"/> Disrespectful | <input type="checkbox"/> Short attention | <input type="checkbox"/> Acts without thinking |
| <input type="checkbox"/> Hateful | <input type="checkbox"/> Whines | <input type="checkbox"/> Demanding | <input type="checkbox"/> Takes risks | <input type="checkbox"/> Uncaring about others |
| <input type="checkbox"/> Abusive | <input type="checkbox"/> Defiant | <input type="checkbox"/> Out of control | <input type="checkbox"/> Manipulative | <input type="checkbox"/> Other: |

Describe any illegal or other activities not covered elsewhere that you are concerned about below or on the back.

Release of information

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Filled out by applicant, parent or guardian, completed by assistant.

Today's date _____

Applicant _____ Age ____ Sex ____ Date of Birth: _____

I hereby authorize Dr. Roitman and his staff to (check all that are applicable):

- exchange information with:
 - only request information from:
 - only release information to:

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

NORTON A. ROITMAN, MD
2340 PASEO DEL PRADO #D 307
LAS VEGAS, NEVADA 89102

Phone 702-222-1812 Fax 702-222-1786 eMail: NRoitmanMD@gmail.com

The purpose of this release of information is to

- Coordinate treatment with other providers
- Verify attendance
- Evaluate status
- Obtain assistance
- Other _____

I release Norton A. Roitman, MD and his staff from any legal liability resulting from the release of this information with the understanding that reasonable professional safeguards will be taken. Unless otherwise specified, release authorization will expire in one year. Release of information is subject to revocation at any time.

Responsible party _____ Staff _____