ID# _____

PATIENT ID _____
(assigned by CMRN)

MONTH OF EXAM

## Medical Examination

| PATIENT INFORMATION | |
|---|---|
| NAME (LAST, FIRST, MI) | DATE OF BIRTH AGE |
| SEX (CIRCLE ONE) MALE / FEMALE | RACE: |
| ADDRESS | PHONE |
| COUNTY | |
| **EXAMINING PROVIDER INFORMATION** | |
| HOSPITAL OR CLINIC NAME:<br>Children's Medical Resource Network | ADDRESS<br>109 Denny Industrial Drive |
| MEDICAL PROVIDER CONDUCTING THE EXAM<br><br>Swafford, Kathy D., M.D. | PHONE: (618)833-6488 |
| LICENSE NUMBER<br>036-074783 | PERSON(s) ASSISTING DURING THE EXAM |
| SIGNATURE OF MEDICAL PROVIDER | PO Box 179<br>1155 East Vienna, Suite C<br>Anna, IL 62906 |
| DATE OF EXAM: | TIME OF EXAM: |

Patient was accompanied to visit by: (list names of people that came to the exam)

_____

I hereby request a medical examination for evaluation of physical or sexual abuse treatment, as needed. I understand that collection of evidence may include photographing injuries and that photographs may include the genital area. I further understand that hospitals and physicians are required to notify the Department of Children and Family Services of known suspect child abuse. If child abuse is found or suspected, this form and any evidence will be released to the Department of Children and Family Services, Law Enforcement, Children's Advocacy Center, and or the Prosecuting Attorney. Demographic data and case review will be provided to the Medical Director of the Children's Medical Resource Network. (Parental consent for an evidential exam is not required in cases of known or suspected child abuse)

**Signature of (circle one) Parent/Guardian** _____ **Date** _____

**Witness signature** _____ **Date** _____

Southern™
Illinois University
School of Medicine

*Children's Medical Resource Network*
Kathy D. Swafford, M.D., Medical Director
Ginger L. Meyer, M.S.W., L.C.S.W., Medical Social Worker

PO Box 179
Anna, IL 62906

618.833.6488
Fax: 618.833.1599

# CONSENT FOR PHOTOGRAPHS

I, _____, hereby authorize representative of SIU School of Medicine/Children's Medical Resource Network, my physician(s) or other designated person(s) to photograph, videotape or use other appropriate electronic media recording of me (hereafter collectively referred to as photographs) while under the care of the above named facility with the following restrictions: (write none if no restrictions – do not leave_____ blank)_____

I understand that these photographs of me are to document my medical condition, or for clinical educational and identification purposes. I further understand that, based on the reason for the photographs they may be maintained as a permanent part of my medical record. I understand the photographs that are maintained by the facility are made a permanent part of my medical record, release of which shall be in accordance with applicable medical information regulations and laws.

I release and hold SIU School of Medicine/Children's Medical Resource Network, its employees, agents, or affiliates and my physician or his/her designees harmless from any and all liability, claims, demands or causes of actions whatsoever arising from and in any way associated with taking, displaying or use of these photographs.

This release and indemnification shall be as broad and inclusive as is permitted by the State of Illinois. If any portion is held invalid, the balance shall continue to be in force and effect.

I certify that I have read, understand and agree to the terms of this consent and release.

_____ _____ _____
Signature of patient or authorized representative | Date | Time

_____ _____
Relationship of authorized representative | Interpreter (if utilized)

_____ _____
Second Witness if telephone consent | Witness

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# AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ hereby authorize SIU School of Medicine/Children's Medical
(Person Signing Authorization)

Resource Network to furnish the following medical information to _____
_____
_____
_____
(Name and Address of Facility)

Patient's Name: _____ Date of Birth: _____

Specific Information to be Released: Date of Treatment: _____

☐ History and Physical-Medical ☐ Laboratory Reports

☐ Social History/Assessment ☐ Other _____

I understand that this authorization includes information regarding mental health, developmental disability, alcohol and/or drug abuse services, and HIV test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

This authorization expires 1 year from the date of issue. I understand that I have a right to revoke this authorization at any time and for any reason, and that such revocation will be honored except to the extent of any action already taken on this authorization prior to revocation. I also understand that I have a right to inspect and have copied all information to be disclosed pursuant to this authorization.

Signed:_____ Date:_____
(Patient/Guardian)

If signed by other than the patient, please indicate relationship to patient, and why patient did not sign:_____
_____
_____

Witness: _____ Date: _____

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*******IMPORTANT ****** PLEASE FILL THIS FORM OUT IN ITS ENTIRETY!!**

## REGISTRATION FORM

(Please Print)

**PATIENTS NAME:** _____
(First) (Middle) (Last)

DOB: _____ AGE: _____ F _____ M _____

ADDRESS: _____ Home phone: _____
(street or mailing address)

_____ School or Daycare: _____
(City) (State) (Zip Code)

SS #: _____-_____-_____

Who referred you to our office? _____

**PERSON (OTHER THAN PARENTS) TO CONTACT IN CASE WE CANNOT REACH YOU:**
(Name) _____ (Phone #) _____

(Address) _____

**PRIMARY CARE PHYSICIAN & CITY:** _____

**PARENT OR GUARDIAN INFORMATION:**
MOM_____ DOB_____ SS#_____-_____-_____

EMPLOYER_____ PHONE #_____

DAD_____ DOB_____ SS#_____-_____-_____

EMPLOYER_____ PHONE #_____

**INSURANCE INFORMATION:**
Name of Insurance: _____

Name of Insured: _____ Group # _____

Member ID #: _____ Employer Insurance Plan?(yes/no)_____

Medicare/Medicaid #: _____

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESSING OF THIS CLAIM. I ALSO AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN FOR HER SERVICE(S) AS DESCRIBED HEREIN.

SIGNED:_____ DATE:_____