Integrative Pharmacists Consulting

Charlene Vernak, Pharmacist
1889 East Lake Road
Skaneateles, New York 13152
315.430.5486 phone
877.812.5417 fax

These items must be completed and on file with the pharmacy prior to your assessment:

- Have your doctor complete the Pharmacist-Physician Collaboration Agreement
- Pharmacy Record Release Authorization Form
- The Consultation and Assessment Form
- Health Insurance Portability and Accountability Act (HIPAA) Form
- Provide copies of any relevant blood and/or saliva tests results if available (ie. testosterone, dhea, estradiol, estrone, cortisol, thyroid, etc.)

Pharmacist-Physician Collaboration Agreement

Your patient, _____, has requested an *Integrative Pharmacy Consult* by our pharmacist Charlene Vernak, RPh doing business as Integrative Pharmacy Consultants.

Our goal is to work with you to help your patient optimize their care by conducting a comprehensive pharmacy evaluation for an individual patient by a pharmacist who is dedicating an appropriate amount of time to evaluate drug interactions, side effects and disease state interactions.

We will review your patient's entire medication list which would include the current drug therapies, vitamins, herbs and supplements.

We use Clinical Pharmacology Software to assist us in our evaluation and to help us to make recommendations regarding traditional medications.

We are available to you and happy to fax or mail this information to your office upon request.

Our assessment includes but is not limited to a review of symptoms, disease states, medical history, family history and submitted labs. In addition we will review current medications, vitamins, herbs and supplements to help to evaluate compliance, patient satisfaction and to secure better results for your patients.

Some patients may not have responded to, did not tolerate or would like to improve upon their current health care regimens with vitamins, herbs and supplements. Our pharmacist, Charlene is trained in compounding, nutrition and metabolic medicine and is prepared to offer reasonable suggestions to augment your current care when non traditional options may be helpful.

We will fax or mail you recommendations and suggestions upon your patients completion of our evaluation and will be available to you to discuss further ideas.

I, _____ (Physician Name), authorize Charlene Vernak, RPh doing business as Integrative Pharmacy Consultants to assess and evaluate _____ (Patient Name), and make recommendations to me regarding my patient's treatment.

Signature: _____

Date: _____

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Health Insurance Portability and Accountability Act (HIPAA) Form

I Have read and agree to the Integrative Pharmacist Consulting Health Insurance Portability and Accountability Act (HIPAA) Form.

Date:

Patient Name:

Parent Name:

I consent to the release of my health information to:

_____

Signature of Patient:

_____

PHARMACY RECORD RELEASE AUTHORIZATION

I, the undersigned patient, authorize my pharmacist to release my personal medication and/or other medical information to the following persons or organizations upon request or as deemed necessary:

NAME	ADDRESS	TELEPHONE
1.		
2.		
3.		

I understand that employees of Integrative Pharmacy Consultants will protect my privacy and this information will be released to other healthcare professionals only when it is necessary in order to provide healthcare services to me. This authority shall continue until revoked by me in writing.

Patient Name:

Address:

City, State, Zip:

Phone:

Signature:

Date:

Male Consultation and Assessment Form

Today's Date_____

Name _____ Date of Birth _____

Address _____

Home Phone _____Cell Phone _____

Email _____

Height _____ Weight _____ Gender_____

Gender _____ Occupation _____

Referring Source_____

Primary Care Provider_____

What are your greatest needs or problems? (List the most important; then list other issues in order of importance):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical Conditions/Diseases: Please check all that apply to **you**.

___ Heart disease (example: Congestive Heart Failure)
___ Blood Clotting Problems
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ Diabetes
___ High blood pressure (example: Hypertension)
___ Arthritis or joint problems
___ Cancer
___ Depression
___ Ulcers (stomach, esophagus)
___ Epilepsy
___ Thyroid disease
___ Headaches/migraines
___ Hormonal Related Issues
___ Eye Disease (glaucoma, etc.)
___ Lung condition (example: asthma, emphysema, COPD)

Other medical conditions: Please list: _____

_____

_____

_____

Drug Allergies: _____

Allergies to food, pollens, environment, etc: _____

Have you recently developed allergies that you have not had before_____

Do you have any sensitivities to chemicals_____

Have you ever taken or are you currently on any hormone replacement therapy? (If so list the medications, including strength & how you take them): _____

_____

_____

_____

Names of ALL prescription and OTC medications you are currently taking (include strength & how you take them):

_____

_____

_____

_____

_____

Indicate any vitamins, herbal products and/or supplements that you have taken and possible adverse reactions to them:

_____

_____

_____

_____

Have you ever had a bone density scan? YES NO

If so when? _____ Results? _____

Lifestyle: If yes, how often and how much?

Do you use tobacco? Yes No _____

Do you use alcohol? Yes No _____

Do you use caffeine? Yes No _____

Do you use recreational drugs? Yes No _____

How much water do you drink in one day (24 hr)?_____

Dietary Restrictions (such as salt, carbohydrates, milk products, red meat, etc): _____

_____

Do you have a FAMILY history of any of the following?

Uterine Cancer	_____	Family member(s) _____
Ovarian Cancer	_____	Family member(s) _____
Fibrocystic breast	_____	Family member(s) _____
Breast Cancer	_____	Family member(s) _____
Heart Disease	_____	Family member(s) _____
Stroke	_____	Family member(s)_____
Hypertension	_____	Family member(s)_____
Diabetes	_____	Family member(s)_____
High Cholesterol	_____	Family member(s)_____
Irritable Bowel	_____	Family member(s)_____
Osteoporosis	_____	Family member(s) _____
Alzheimers	_____	Family member(s)_____
Anxiety disorder	_____	Family member(s)_____
Depression	_____	Family member(s)_____

Other notable family history: _____

_____

_____

_____

Describe your bowel habits:

_____

_____

_____

Are you regular:_____

Are you often constipated_____

Do you regularly have diarrhea?_____

How often do you have a bowel movement?

_____

Do you suffer from bloating?_____

Do you suffer from stomach cramps?_____

Do you suffer from gas?_____

Do you have inflammation in the abdominal area?_____
Do you suffer from heartburn?_____

Other abdominal issues:

_____

When was your last general medical exam: _____

Have you ever had surgery? Please give dates and Describe_____

_____

_____

Have you ever been diagnosed with an autoimmune condition? If so, please describe

_____

Has anyone in your family ever been diagnosed with an autoimmune condition?

_____

Have you ever had a serious infection (example...EBV or mononucleosis, Lymes disease, Hepatitis, etc). If so, please list.

_____

_____

Have you ever been diagnosed with anemia, vitamin d deficiency or or any other type of nutritional deficiencies?

_____

Do you have a history of any skin issues such as eczema, psoriasis or long standing acne?_____

Describe the quality of your skin_____

Do cuts heal easily_____

Do you scar easily_____

Do you bruise easily_____

Any history of skin issues or conditions in the past. Please describe.

_____

_____

_____

Describe the quality of your nails:

_____

_____

Any recent changes_____

Ridges-vertical_____

Ridges-Horizontal_____

Discoloration_____

Indentations_____

Any Peeling_____

Strong, brittle, tear easily or in between_____

Any Thickening of the nail beds_____

Describe the quality of your hair.

_____

Any changes in texture_____

Is it drier than
normal_____

Is it falling out? If so where

_____

_____

How Stressed are you? Please describe emotional, physical, family or work related stres that might be interfering with your overall health

_____

_____

What do you do to manage stress_____

_____

Are you happy with your sex drive_____

_____

Are you able to achieve orgasm? Has your ability to achieve orgasm changed?_____

_____

If you are sexually active, is intercourse painful?_____

_____

Does vaginal dryness or pain interfere with sexual pleasure or orgasm?_____

_____

Do you exercise, if so please describe

_____

_____

Describe your sleep-Any difficulty falling asleep_____

_____

Difficulty staying asleep_____

what wakes you up at night_____

do you feel refreshed in the morning_____

Max average hours of sleep in a row_____

Max average hours of sleep per night

_____

Do you suffer from fatigue during the day? If so, is it worse at certain times of the day?

_____

_____

Do you have difficulty staying awake during the day? Do you spontaneously fall asleep without trying?_____

Have you gained an unusual amount of weight in a short amount of time? If so, please describe:_____

_____

_____

If so, where has the fat accumulated?

_____

_____

Do you have difficulty building muscle? If so, Please describe

_____

_____

Do you break out into sweats? If so, how often

_____

Have you ever been told that your blood sugar is high, but not been diagnosed with diabetes?_____

_____

Do you have hot flashes? If so, please describe and list how many per day?_____

_____

Do you have body pain? If so, please describe

_____

Location of pain : is it all over or in specific areas_____

Is it bone pain, tissue pain, please describe

_____

Does your pain limit your daily activities?_____

Does your pain affect your sleep?_____

Do you have high blood pressure or does your blood pressure elevate when you are upset?_____

_____

If your doctor has recently ordered lab tests or diagnostic procedures for you, please give details, including whether the test or procedure was performed, and the results:

_____

_____

Symptom Check List

Please check all symptoms and the degree of the symptoms intensity you have experienced over the past 3 months. If you wish to add comments or details, please do so on the last page.

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Heavy menses	_____	_____	_____	_____
Irregular Menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Dry Skin	_____	_____	_____	_____
Dry Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Nervousness	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Vaginal Discharge	_____	_____	_____	_____
Vaginal Itchiness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Sleep Disturbances/Insomnia	_____	_____	_____	_____

Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Retention	_____	_____	_____	_____
Urinary Leakage	_____	_____	_____	_____
Urinary Retention	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Decreased Stamina	_____	_____	_____	_____
Painful Intercourse	_____	_____	_____	_____
Increased sex drive	_____	_____	_____	_____
Excessive sweating	_____	_____	_____	_____
Excessive Thirst	_____	_____	_____	_____
Hair Loss (scalp)	_____	_____	_____	_____
Loss of Pubic Hair	_____	_____	_____	_____
New Hair Growth (face)	_____	_____	_____	_____
New Hair Growth (body)	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Sugar Cravings	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Constipation	_____	_____	_____	_____

Diarrhea	_____	_____	_____	_____
Heartburn	_____	_____	_____	_____
Bloating/Gas	_____	_____	_____	_____
Feeling Cold	_____	_____	_____	_____
Feeling hot	_____	_____	_____	_____
Breast Discharge	_____	_____	_____	_____

Other symptoms not listed or in depth description of symptoms listed above:

_____

_____

_____

_____

_____

_____

Please write down any questions you have that we didn't address on this form

_____

_____

_____

Please Note:

The recommendations you will receive from Charlene Vernak, Integrative Pharmacist Consulting are made based on mutual engagement from the patient and from your other medical providers. In order to achieve the best results we need feedback from both you and your provider as to the status of our recommendations. Follow up labs to evaluate improvement would be a tremendous asset to our ongoing relationship to assess improvement in your health. We are striving for lab optimal. If you are looking for recommendations on compounded bioidentical hormones we would request saliva testing and basic labs as a gold standard to measure your progress. We would request to discuss these labs with your provider at the onset of treatment, once established and then every six months to one year while on custom hormone therapy based on the health of the patient. Please forward and discuss this information with your medical provider.