

Welcome to the UW Health Sports Medicine Clinic

You are scheduled on _____ to see _____.

In order to best serve your needs, please bring with you to your appointment the following:

1. Completed Questionnaire (enclosed)

2. Imaging

Hand carry any plain x-rays, MRI scans, CT scans, etc. that you may have had done at another facility. Radiology reports are not sufficient; we need the actual film and report. Typically, we require the x-rays to be 1 year old or less. If your insurance will not allow films to be done here, you may want to have new ones done at your clinic.

3. Medical Records

Please bring any previous operative notes.

4. Insurance Referral (if needed)

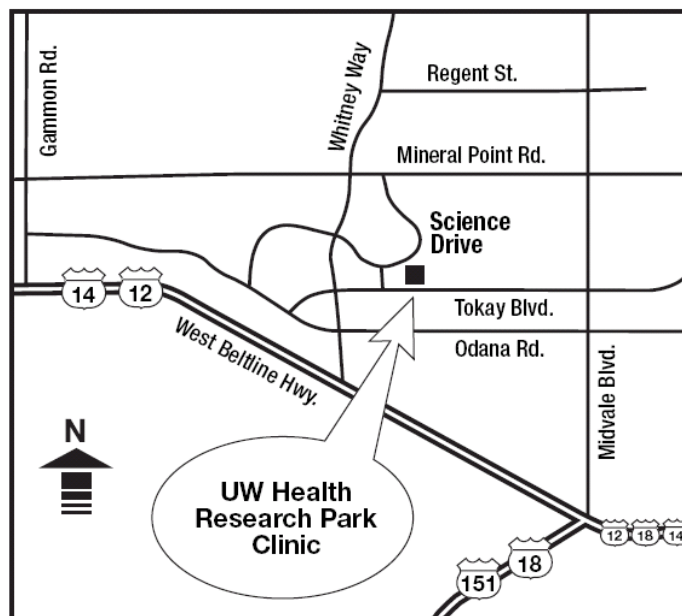
If you belong to an HMO, bring a copy of your referral with you. If this is a worker's compensation claim, bring the claim number, the name of the insurance company and the address where the claim should be sent.

If you have any questions regarding your upcoming appointment, please do not hesitate to give us a call at (608) 263-8850.

Directions

The Sports Medicine Clinic is located at the UW Health Research Park Clinic, 621 Science Drive, Madison, Wisconsin. (608) 263-8850 Fax (608) 265-8340.

- From the east – take Mineral Point Road west and turn left on Science Drive (before Whitney Way).
- From the west – take Mineral Point Road east, turn right on Whitney Way and left on Science Drive.
- From the beltline (12&18) – take Whitney Way exit north, go straight through intersections of Odana and Tokay and turn right on Science Drive.



Welcome to the UW Health Sports Medicine Clinic

To help you better prepare for your clinic visit with us, please review the following information. This comprehensive list outlines what to expect, as well as the health care providers you may encounter at a typical clinic visit. Your visit with us may or may not include all of the services listed below. Thank you again for choosing the UW Health Sports Medicine Clinic as your health care provider.

1. **Check-in and Waiting Area:** Registration/check-in will be as you enter the clinic building. After checking in, proceed to the second floor waiting area. If you are a new patient to our clinic and have not filled out the patient health history questionnaire, please obtain one at the second floor information desk.
15-20 minutes
2. **Electronic Medical Record Update:** A medical assistant (MA) will bring you from the waiting area and take you to your clinic room. The MA will then update your current medications and health status in your electronic medical record.
3. **Preliminary Examination:** You will be seen by the physician's resident, physician assistant, nurse practitioner, athletic trainer, or a physical therapist who will note your history, perform a preliminary physical examination, and determine if you need radiographic films.
15 minutes
4. **Radiology:** If you need new x-ray films, you will be sent down the hall to radiology. You may be asked to change into shorts or a gown for x-rays. You will then return to your clinic room, and your films will be sent electronically to your room; you do not need to hand-carry any films.
10-30 minutes
5. **Physician Evaluation & Assessment:** The physician will review your history and repeat essential parts of the physical examination. At the completion of this assessment, the physician will provide you with a diagnosis and a comprehensive treatment plan.
20 minutes

This plan may include, but is not limited to, the following:

- **Prescription for Braces/Orthotics:** Depending on the type of orthotic prescribed, you may see the orthotic technician at your clinic visit or you may be asked to schedule an appointment at a later date.
- **Consult for Sports Rehabilitation:** You may schedule a sports rehabilitation appointment at any provider who is covered by your insurance. Please bring the consult form to your initial sports rehab visit.
- **Referral to other health care providers:** Contact information will be provided at your clinic visit. Appointments may be scheduled at the Sports Medicine clinic front desk, or you may be directed to schedule them on your own.
- **Follow-up Appointment:** An appointment sheet provided at the end of your visit should be taken to the Sports Medicine Clinic front desk to schedule your next appointment.

****Please allow approximately 90 minutes for your initial clinic visit****

Welcome to our clinic

Welcome!

Welcome to our clinic. Thank you for the opportunity to be a partner in your health care. At UW Health we strive to provide the best possible care. Our clinic is part of the University of Wisconsin. In addition to your physician, nurse practitioner or physician assistant, you may be seen by a resident physician, medical student, athletic trainer or advanced practice nursing student.

Telephone Availability

Feel free to call any time you have concerns about your health. If you call the clinic before 4 p.m. we will make every effort to respond that day. If your call is urgent, we will review your needs and arrange for care.

To respect your privacy, we will not leave information on answering machines or share information regarding patients over the age of 18 without their permission.

After Hours Care

In the event of an emergency, call 911. For urgent questions or concerns, please call (608) 262-2122. You will be connected to the answering service. They will contact the physician on call. Our doctors admit patients to UW Hospital.

Prescriptions

Before you run out of a prescribed medication, you can renew as follows:

1. Ask your doctor during your appointment.
2. Call your pharmacy, who will contact your doctor for you.

Please contact your pharmacy at least 48 hours before your medication runs out.

Lab Work/Tests

You will be contacted with your test results within 14 days unless your doctor tells you otherwise. If you have not received your test results after two weeks, please call the clinic at (608) 263-8850.

Appointments - Outpatient Attendance

Please schedule your return appointment before leaving. If you have questions or concerns before your next scheduled appointment, don't hesitate to call the clinic. If you have changes in your medication, allergies or current health, please share with your provider at your next scheduled appointment. If you need to cancel an appointment, please call us as soon as possible. This allows us to meet the needs of other patients.

Please contact our registration department at (608) 262-1400 with any changes of address or insurance. We require verification of information through registration every 120 days. Contacting our registration department before your appointment will prevent delays.

Resources

Question/Concern	Resource	Contact Information
Insurance	Please call your insurance company to verify coverage for therapy services.	
Billing	Patient Billing Service	(608) 262-2221 or (866) 841-8535
Pricing	Priceline	(608) 263-1507
Financial Hardship	Community Care Line	(608) 262-2221 or (866) 841-8535
Other Questions	Patient Relations	(608) 263-8009
On-Line prescription renewal	Pharmacy	uwhealth.org/rx



University of Wisconsin Hospital and Clinics

600 Highland Avenue • Madison, Wisconsin 53792

PATIENT HEALTH QUESTIONNAIRE

UW Health Sports Medicine Clinic
Patient Health Questionnaire

Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Referring Physician: _____

What problem can we help you with today? _____

What was the date of injury? or How long have you had this problem? _____

Rate your pain on a scale of 0 to 10 (0 = no pain, 10 = worst pain you ever had).

Today: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

Please rate the level to which you feel the following activities are affected by your current problem.
(0 = no affect, 10 = unable to perform)

Sports: 0 1 2 3 4 5 6 7 8 9 10
Work: 0 1 2 3 4 5 6 7 8 9 10
Sleep: 0 1 2 3 4 5 6 7 8 9 10
Daily Activities: 0 1 2 3 4 5 6 7 8 9 10

Would you describe your pain as: (check all that apply)
 constant on/off sharp dull achy
 burning pressure tingling/electrical

Has any other medical provider seen you for this problem? Yes ___ No ___
If yes, who? _____

Have you had an x-ray for this problem? Yes ___ No ___
Have you had an MRI for this problem? Yes ___ No ___
Have you had an CT for this problem? Yes ___ No ___
Have you had an EMG for this problem? Yes ___ No ___
Where were they performed? _____
Did you bring them with you today? Yes ___ No ___

Were you ever given a diagnosis by another provider for this problem? Yes ___ No ___
If yes, what was the diagnosis? _____

Have you used any of these techniques for treatment and/or pain control? (check all that apply)
 Rest Ice Ibuprofen (Advil, Motrin) Physical Therapy (Duration) _____
 Aspirin Tylenol Naproxen (Aleve) Splint/brace
Other (please list) _____

Do you currently have any fevers, chills, or redness associated with your pain? Yes ___ No ___

Do you currently have generalized achiness or pain/achiness in other joints? Yes ___ No ___

Do you have any of the following symptoms?

- muscle weakness loss of range of motion locking/catching
- feeling of giving way/dislocation tenderness to touch limp
- numbness or tingling loss of sensation swelling
- unexplained weight loss

Do you take any medications? Yes No

Please list:

Name of Medication	Condition Treated	Name of Medication	Condition Treated

Do you have any medication allergies? No Yes To what? _____
If yes, what kind of reaction do you have? _____

Do you have an allergy to latex? No Yes
If yes, what kind of reaction do you have? _____

Have you had previous surgery? If yes, what?
side

- 1. R L Body Part : _____ Surgeon: _____ Year: _____
- 2. R L Body Part : _____ Surgeon: _____ Year: _____
- 3. R L Body Part : _____ Surgeon: _____ Year: _____
- 4. R L Body Part : _____ Surgeon: _____ Year: _____
- 5. R L Body Part : _____ Surgeon: _____ Year: _____

Do any of your close relatives have any bone or joint problems? Yes No
If yes, what problems do they have? _____

Do you have or have you ever had any of the following?

- High blood pressure Asthma Arthritis
- Heart disease/Heart attack COPD/Emphysema Cancer
- Heart/Bypass surgery Tuberculosis Hepatitis
- Angioplasty Seasonal allergies Migraine headaches
- Blood clots Stomach ulcers Stroke
- Diabetes Acid reflux/ heart burn
- Kidney disease Rheumatoid arthritis/Lupus/Autoimmune disease(circle)

Do you have any other medical problems that you think we should know about? Please list:

Do you smoke? Yes No How many packs/day? _____ How long? _____

Do you drink alcohol? If yes, how many drinks per week? _____

Is this a Workers Compensation injury? Yes No

Are you currently working? Yes No
If yes, are you on light duty? Yes No

What is your occupation? _____

Thank you for taking the time to provide this information to us. It is very helpful as we work to provide you the best, most efficient and most effective care possible.

The UW Health Sports Medicine Staff

Completed by _____	Date _____	If not patient, relationship to patient _____
Reviewed by _____	Date _____	Time _____