PREScription FOR INFORMATION

Patient Name: ________________________ Date: ______________
Treatment Unit: ______________________

Description of Information Request:

Background information about condition/any complicating factors that should be considered in the information retrieval:

______________________________________________
Healthcare Provider Signature

______________________________________________
Healthcare Provider Printed Name

Telephone/beeper Number: ______________________
Contact information and packet preferences for patients/family members:

Street: ___________________________________________________          Apt: _________________

City:   _______________________________________    State: ___________        Zip Code: ________

Phone: _________________ (home)                  _______________ (hospital)           _______________ (other)

Patient age: _________              Male / Female                E-mail: _______________________________
   (circle one)

Type of information you prefer (check one or more):

☐ General                  For individuals with limited experience with health information
                              Terms are explained and summaries are easy to understand

☐ Intermediate            For individuals with some knowledge about health information
                              Clarification of complex terms and topics are provided

☐ Advanced                For healthcare professionals or individuals with extensive knowledge of
                              health information. Summaries provide a synthesis of available evidence

Please mark your language preference: (Limited selection of non-English materials available)

English_____        Spanish_______        Other (list)___________

How would you like to receive the information packet?

Pick-up at the library_____        Deliver to hospital _____            Mail to home_____

Please sign if you understand the following:

• A copy of the information packet will be forwarded to the patient’s doctor.
• The information packet may take 3-5 days to complete.
• A staff member working on the packet may call to clarify the request and/or let me know that the
  packet is complete.
• The staff member working on this packet does not have access to patient medical records.
• All patient information is kept confidential.
• I may call to speak with a Patient Information or Clinical Librarian at 936-1410 for more
  information about my request.

Signature: ________________________________        Date: ____________________