

Indigent Drug Program (IDP) Consent Form

I give my permission to Angels Community Clinic Pharmacy Manager or Staff to act as my agent for the purpose of signing all Indigent Drug Program (IPD) applications from any pharmaceutical company on my behalf. I also authorize Astra-Zeneca and any other Pharmaceutical companies who need to review my patient files for audit purposes only as required by the Program business rules.

I understand that the applications are required to obtain my medications. This consent will remain valid as long as I am a patient of Angels Community Clinic or until I revoke my permission in writing.

Patient Name, print: _____

Patient Signature: _____

Date signed: _____

Patient Date of Birth: _____

Patient SSN: _____

Witness Signature

Pharmacy Manager “OR” Front Office Personnel:

Name/Signature: _____

ELGIBILITY REQUIREMENTS
ANGELS COMMUNITY CLINIC

- Patients must be employed or have worked within the last 6 months. Unemployed patients must be actively seeking a job.
- Patients must reside in Calloway County.
- Patients cannot have private insurance or be receiving state or federal aide.
- Patients that are veterans of the US Military services are eligible for treatment and medications through the Veterans Administration.
- Patients injured on the job are not eligible for treatment for their work-related injuries or illnesses.
- Patients on disability with a medical card cannot receive treatment. If on disability the must show proof of employment.
- Patients who are **drunk or seeking controlled substances** are not eligible for treatment.
- Patients that are **rude, use foul language, are openly unappreciative, or are verbally abusive are not eligible for treatment.**
- Patients requesting testing for sexually transmitted diseases will be referred to the Health Department.
- Patients requesting services related to family planning will be referred to the Health Department.
- Patients that do not sign the Patients Responsibilities Form or who violate the conditions of the form are not eligible for treatment.

Signature _____ Date _____

Witness _____ Date _____

Please answer the following questions about Angels Community Clinic:

1. Have had any type of insurance in the last year _____ Yes _____ No.

If so, what kind (medical card, etc.) _____

2. How did you hear about Angels Community Clinic?

Newspaper _____ Friend _____ Another medical facility _____

Other _____

3. Are you aware Angels Community Clinic is funded by donations from the community with no assistance from the state and government? ____ Yes ____ No.

4. Would you feel uncomfortable donating money in order that Angels Community Clinic can continue to provide medicines free of charge? _____ Yes _____ No.

5. If Angels Community Clinic has to start requesting donations of money for medicines what do you think would be a fair amount? \$ _____

6. Would you have been treated elsewhere if Angels Community Clinic was not here to serve you?

Would you have put it off? _____ Yes _____ No.

Not been checked by anyone? _____ Yes _____ No.

Gone to the Emergency Room? _____ Yes _____ No.

7. How many times have you been seen in the local Emergency Room in the last year? _____. For what reason? _____.

8. Any other comments or suggestions that you have, to help serve you in the future, would be appreciated. _____

_____.

Date _____

Signature(optional) _____

**Angels Community Clinic
Patient's Personal History**

Date _____

Patient's Full Name _____

Birthdate _____ Age _____

Who has been your medical care provider in the past and when did you last see him/her?

MEDICAL HISTORY:

1. List all medications you are allergic to: _____

2. Briefly state your reason for this visit: _____

3. List all medications you are taking (include birth control pills and aspirin): _____

4. Medical Problems other than surgery (i.e. diabetes, heart attack, cancer, TB, rheumatic fever, glaucoma, free bleeding, asthma, allergies, major injuries): _____

5. Past History of Surgeries (Please list all operations you have had and the dates):

6. Do you smoke? _____ Cigarettes _____ Pipe _____ Cigars _____

How long? _____ How much? _____

7. Females Only: Date last menstrual period _____

Date last pap smear _____ Date last mammogram _____

Number of pregnancies _____ Number of children born alive _____

Review of Symptoms (Do you have any of the following?):

Head-Ears-Eyes-Neck-Throat:

Dizziness _____ Headaches _____ Visual Problems _____ Sinus Trouble _____

Pulmonary:

Cough _____ Pain with Breathing _____ Coughing Up Blood _____

Shortness of Breath _____ Asthma _____

Cardiac:

Chest Pain _____ Leg Cramps with Walking _____ High Blood Pressure _____

Abnormal Heart Beat _____ Mitral Valve Prolapse _____

Gastrointestinal:

Difficulty Swallowing _____ Constipation _____ Blood in Stool _____

Vomiting _____ Ulcers _____ Hemorrhoids _____

Neuroloigical:

Seizures _____ Passing Out _____ Stroke _____

Family History:

Please check if there is a family history of any of the following:

Cancer _____ Heart Attacks _____ Sickle Cell Disease _____

Glaucoma _____ High Blood Pressure _____ Arthritis _____

Diabetes _____ Bleeding Problems _____ Kidney Disease _____

TB _____ Kidney Stones _____ Other _____

Immediate Family: Living or Deceased
Age, Health, Age at Death, Cause of Death

Father _____

Mother _____

Brothers _____

Sisters _____

RELEASE OF INFORMATION – ALL PATIENTS

I hereby authorize Angels Community Clinic to release my medical records, including any laboratory results, to whomever they deem necessary for my treatment.

Signature

Date: _____