Patient Intake Forms

DVCSTEM

To begin the onboarding process please fill out these intake forms and submit them to our patient management team. Once completed, you will receive a list of labs & exams that must be submitted and reviewed prior to receiving final treatment clearance.

Please complete this form as accurately and completely as possible.

Patient Information

Full Name

Date of Birth

Gender

Height

Weight

Marital Status

Occupation

Contact Information

Email address

Primary Contact Number

Full Mailing Address **(for pre-treatment supplements)**

Emergency Contact Information

Full Name

Relationship

Primary Contact Number

DVCSTEM

Medical History

Please be as thorough as possible. **Any misrepresentation or omission of pre-existing conditions or co-morbidities could delay the onboarding process or result in exclusion from treatment participation.**

Current medical impressions/diagnosis/prognosis

Please check any existing or pre-existing conditions below

- [ ] **Cardiovascular Issues**
- [ ] **Circulatory Issues**
- [ ] **Gastrointestinal Issues**
- [ ] **Respiratory Tract Issues**
- [ ] **Thyroid Issues**
- [ ] **Mobility Issues (that may impact ability to travel**

Please describe any existing or pre-existing conditions

Past surgical history / hospitalizations

Allergies (Food and Medication)

Please list any special medical requirements / needs that our medical team should be aware of

PAR-Q FORM

DVCSTEM

The PAR-Q is a self-screening tool that is typically used to determine the safety of travel and treatment based on your health history, current symptoms, and risk factors. This information will also be used to create a baseline in order to measure treatment results. **Please complete this form as accurately and completely as possible.**

General Evaluation

Please mark YES or NO to the following

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes No

Do you feel pain in your chest when you do physical activity? Yes No

In the past month, have you had chest pain when you were not doing physical activity? Yes No

Do you lose your balance because of dizziness or do you ever lose consciousness? Yes No

Is your doctor currently prescribing drugs (eg. water pills) for blood pressure or heart condition? Yes No

Please list all medications you are currently taking (if applicable)

Describe recent surgeries (if applicable)

Do you have partial or complete loss of vision? **If yes, which eye?** Yes No

Slurred or unclear speech? Yes No

Hearing issues? **If yes which side?** Yes No

DVCSTEM

Lifestyle qustionnaire

How often do you smoke? 0

How often do you drink alcohol? 0

How many hours do you regularly sleep? 12+ hours

Describe your job

Rate your level of stress between 1-10
1 = no stress 10 = high stress 10

List your three biggest sources of stress
(If applicable)

Nutrition questionnaire

On a scale 1-10, how would you rate your nutrition?
1 = very poor 10 = excellent 5

How many times a day do you usually eat?
(including snacks) 1-2 times per day

Do you skip meals? Yes No

Do you eat breakfast? Yes No

How many glasses of water do you drink daily? 3-5 per day

Do you feel drops in your energy level throughout the day? Yes No
If yes, when? Early Afternoon

List any multivitamins or supplements you are taking

Besides hunger, what other reasons do you eat?

Do you eat past the point of fullness? Yes No

How often do you eat vegetables? 1-2 times per week

How often do you eat fruit? 1-2 times per week

DVCSTEM

Mobility questionnaire

How would you rate your ability to flex and extend your arms/ hands? Good Fair Poor

Explain the difference between left and right arms/hands

Rate your ability to flex and extend your legs Good Fair Poor

Explain the difference between left and right legs

Ability to walk short distances (within your home) Good Fair Poor

Ability to walk longer distances (supermarket, shopping mall) Good Fair Poor

Do you experience numbness or weakness in one or more limbs? **If yes, please provide details** Yes No Sometimes

Do you experience tremors? **If yes, please provide location** Yes No Sometimes

Do you experience pain in any part of your body? **If yes, please provide location** Yes No Sometimes

Fitness questionnaire

On a scale 1-10, how would you rate your level of fitness? **1 = very poor 10 = excellent** 0

How many times do you exercise per week? 0 1-2 3-4 5-7

What activities are you currently involved in?

Cardio training Yes No Sometimes

Strength training Yes No Sometimes

Stretching Yes No Sometimes

Physiotherapy Yes No Sometimes

If your participation is lower than you would like, what are the reasons?

Vitality Questionnaire

DVCSTEM

Subjective Memory

Please indicate a number that best identifies your response toward each statement
1 = poor
10 = excellent

How would you rate your memory?	1	2	3	4	5	6	7	8	9	10
How is your memory of recent events? (today)	1	2	3	4	5	6	7	8	9	10
How is your memory of past events? (10 years)	1	2	3	4	5	6	7	8	9	10

Overall Health

Physical fitness	1	2	3	4	5	6	7	8	9	10
Flexibility	1	2	3	4	5	6	7	8	9	10
Energy level	1	2	3	4	5	6	7	8	9	10
Balance	1	2	3	4	5	6	7	8	9	10
Coordination	1	2	3	4	5	6	7	8	9	10
Reaction time	1	2	3	4	5	6	7	8	9	10
Strength	1	2	3	4	5	6	7	8	9	10
Stamina	1	2	3	4	5	6	7	8	9	10
Vision	1	2	3	4	5	6	7	8	9	10
Libido	1	2	3	4	5	6	7	8	9	10
Sexual function	1	2	3	4	5	6	7	8	9	10
Quality of sleep	1	2	3	4	5	6	7	8	9	10

DVCSTEM

Subjective Overall Health (Continued)

Ability to concentrate	1	2	3	4	5	6	7	8	9	10
Ability to make decisions	1	2	3	4	5	6	7	8	9	10
Stress level	1	2	3	4	5	6	7	8	9	10
Confidence	1	2	3	4	5	6	7	8	9	10
Motivation	1	2	3	4	5	6	7	8	9	10
Symptom management	1	2	3	4	5	6	7	8	9	10
Daily pain level	1	2	3	4	5	6	7	8	9	10
Thickness of hair	1	2	3	4	5	6	7	8	9	10

Informed Consent Form

Impact and safety of the utilization of culture expanded allogeneic mesenchymal stem cells deployed via intravenous injection for treatment of Chronic Inflammation.

Study doctor: Louis A. Cona, MD
Study location: 31000 Georgetown, Grand Cayman, Cayman Islands, KY1-1205

Outlined below are the consent form categories that must be reviewed and signed prior to final treatment clearance.

- **Informed consent**
- **HIPPA Authorization for disclosure of medical information**
- **Authorization for and consent to surgery or special diagnostic or therapeutic procedures**
- **Photography consent**
- **Photography disclaimer**
- **Disclosure statement**
- **Investigational procedure and on-going follow up participation acknowledgement**

DVCSTEM

Informed Consent

I, _____ have been advised and consulted about the infusion of allogenic cord tissue derived stem cells and I understand and voluntarily consent and authorize the procedure.

I have been explained the technique requires the injection of allogenic cord tissue derived stem cells . The site of injection is according to my specific condition, and can be ( ) local by spray, ( ) local by injection, ( ) subcutaneous, ( ) intravenous-IV, ( ) arterial catheterization.

I have been informed that even though this is not necessarily an FDA approved procedure, this procedure has been used safely and successfully on other patients.

I understand I am electing to have an "investigational procedure" involving the use of cord tissue-derived stem cells. This means that this procedure is not currently the standard of care in the medical community, though it stands within the "Practice of Medicine.

I understand the possible benefits of the procedure are improved function and quality of life. Like any medical or surgical procedure, any individual patient may or may not respond to this procedure as much as expected or even at all. By signing this form you acknowledge that there is no guarantee being provided that this procedure will be effective for your medical condition.

I have been informed that the alternatives to stem cell transfer are not to have this procedure and pursue more conservative therapies.

I have been informed that, while we believe the risk of complications with this procedure to be very low, the risks and complications of adipose tissue harvesting and stem cell infusion can be:

- Immediate pain at the injection site
- Bruising
- Infection
- Nausea/vomiting
- Malaise and Low grade fever
- Itching at injection site
- Allergic reaction
- Nerve or muscle injury
- Dizziness or fainting
- Swelling after injections

I understand that this procedure is usually not covered by insurance and I am responsible for the total charges.

I certify that I understand all the information above in its entirety, have had my questions answered, and potential side effects explained.

Name_____ **Participant's Signature**_____ **Date:**_____

Witnessed by:_____ **Signed:**_____ **Date:**_____

DVCSTEM

HIPPA Authorization for Disclosure of Medical Information

Authorization for Disclosure of Medical Information

Individual's Name _____

Individual's Date of Birth _____

Other Identifying Information (if applicable) _____

I hereby authorize Dr. Louis Cona to use and/or disclose the above-named individual's protected health information (i.e., medical information or PHI), including any and all documents containing information regarding any amendment of such information in the medical records, as described below, for the period of one year.

- ✓ **Complete medical records withiout limitation**
- ✓ **Office records**
- ✓ **Psychological and psychiatric records**
- ✓ **X-rays, CT scans, MRI films**
- ✓ **Radiological records or films**
- ✓ **Histories and physicals**
- ✓ **Operating room records**
- ✓ **Progress notes**
- ✓ **Consultations**
- ✓ **Nurses' notes**
- ✓ **Communicable disease testing / treatment records**
- ✓ **Medication records**
- ✓ **Social workers' records**
- ✓ **Consent for treatment**
- ✓ **Physician's records**
- ✓ **Surgeon's records**
- ✓ **Consultant's reports**
- ✓ **Photographs**
- ✓ **Pathology materials, slides, and tissues**
- ✓ **Laboratory reports**
- ✓ **Discharge summaries**
- ✓ **Patient intake forms**
- ✓ **Prescriptions**
- ✓ **Vital statistics records**
- ✓ **Correspondance**
- ✓ **Therapist's notes**
- ✓ **Insurance records**
- ✓ **Statements of account, itemized bills, invoices**

This medical information may be disclosed to and used by the following. *Please provide the contact info for your home physician or other POC that we may release medical information to, if requested or necessary.*

Name of Person or Institution _____

Address of Person or Institution _____

For the purpose of: _____

Additional Person's listed Yes ○ No ○

DVCSTEM

HIPPA Authorization for Disclosure of Medical Information

I understand that the health information that will be used and disclosed as a result of this authorization may include medical records or treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse, and may also include records or treatment for sexually transmitted disease, HIV, AIDS,-related information, and mental deficiencies.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and must present my written revocation to Dr. Louis Cona. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company where the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify an expiration event of condition, this authorization will expire in six (6) months, except to the extent that action has been taken thereon. In addition, a copy of this authorization may be used in place of the original.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable confidentiality rules. If I have questions about the use or disclosure of my health information, I may contact

Dr. Louis Cona at The Davinci Wellness Centre 345-943-2002

Signature of Individual and/or Legal Representative

Name_____ **Participant's Signature**_____ **Date:**_____

Witnessed by:_____ **Signed:**_____ **Date:**_____

Authorization for and consent to surgery or special diagnostic or therapeutic procedures

To: Patient _____

Your attending and supervising physician is Dr. Louis Cona. The Davinci Wellness Centre maintains personnel and facilities to assist Dr. Louis Cona in this performance of various surgical operations and other special diagnostic or therapeutic procedures. There operations and procedures may all involve risks of unsuccessful results, complications, injury or even death, from both known and unforeseen causes and no warranty or guarantee is made as to result or cure.

You have the right to be informed of such risks as well as the nature of the operation or procedures, the expected benefits or effects of such operation or procedure and the available alternative methods of treatment and their risks and benefits. You have the right to be informed of the likelihood of success, and problem(s) associated with recuperation and the possible result of non-treatment.

DVCSTEM

Authorization for and consent to surgery or special diagnostic or therapeutic procedures

You also have the right to be informed whether your physician has any independent medical research or economic interests related to the performance of the proposed operation or procedure. You also have the right to be informed if the facility or its' staff have any business relationship between individuals treating you or with any educational institutions involved in your care. You have the right to be informed of any professional relationship to another healthcare provider or institution that may suggest a conflict of interest. Except in the cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance.

Your physician(s) and surgeon(s) have recommended the following operation or procedure(s):

Allogeneic Stem Cell Therapy for _____

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which in the option of the supervising physician or surgeon may be indicated due to any emergency will be performed on you. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the facility or your supervising physician or surgeon. They are independent contractors and therefore are your agents, servants or employees.

By your signature below, you authorize the pathologist to use his or her discretion in disposing of any member, organ or other tissue removed from your person during the operation or procedures set forth above.

To make sure that you fully understand the operations or procedure, your physician will fully explain the operation or procedure to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them.

Your signature on this form indicates that: (1) you have read and understood the information provided in this form; (2) that the operation or procedure set forth above has been adequately explained to you by your physician; (3) that you have had a chance to ask questions; (4) that you have received all of the information you desire concerning the operation or procedure; and (5) that you authorize and consent to the performance of the operation or the procedure.

The operation(s) or procedure(s) will be performed by the supervising physician or surgeon names above (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff of the facility to whom the supervising physician or surgeon may assign designated responsibilities.

Patient Print Name_____ **Partient Signature**_____ **Date:**_____

Witnessed by:_____ **Signed:**_____ **Date:**_____

DVCSTEM

Disclosure Statement

Because the Adult Stem Cell Therapy is within the scope of Practice of Medicine but not necessarily the "standard of care", the following important disclosures are made:

The science of treatment with adult stem cells is in its early stage and for most diseases or medical conditions neither prospective, randomized clinical trials, nor long-term studies have yet been completed; therefore no guarantee of effectiveness or safety is made or implied.

Treatments are investigational and are always provided by licensed medical doctors. The allogeneic stem cell treatment will be performed only after the patient understands and agrees to this disclosure and signs a standard informed consent of treatment.

Upon this Disclosure Statement and the Medical History Form have been received back in our office together with your complete medical records, including laboratory and imaging work in reference to your medical condition, you will be contacted within the following two working days for a personal evaluation with a physician, either in person, Video-Call or telephone if you live out of town.

The results of any testimonials of people and/or patients who have undergone stem cell treatment are authentic but may not be necessarily typical. If you need more information, please call us at 345-943-2002

I have read and understand all of the statements above.

Patients Name_____ **Patients Signature**_____ **Date:**_____

Investigational Procedure and On-Going Follow Up Participation Acknowledgement

By signing this form you will agree that you are electing to have an "investigational procedure" involving the use of allogeneic stem cells as part of a clinical study. This means that this procedure is not currently the standard of care in the medical community. As a result, we are requesting you provide to the sponsor of his study data about your health and diseases status on an on-going basis. The data provided to the sponsor will be used to evaluate the safety and long-term outcomes of these therapies and your data may be used as part of scientific presentations or publications. Your personal privacy is assured and guaranteed: all information about patients, their conditions, and/or outcomes will be made anonymous to assure compliance with patient privacy laws and regulations

This data may be collected in any of the following fashions:
Direct follow up with a physician.
Direct, electronic or voice follow up by the physician or a physician's representative.
By signing this form you acknowledge your willing participation in long-term collection, evaluation and reporting of outcomes stemming from this treatment.

Patients Name_____ **Patients Signature**_____ **Date:**_____

DVCSTEM

Photography Consent

TO CONSENT TO PHOTOGRAPHY

☐ I authorize that any pictures taken of my treatments sites may be used for patient's documentation or treatment areas, especially for comparison of results. I have been informed that most complete confidentiality about personal specifics will be maintained at all times.

☐ I authorized the use of these pictures for purpose of education, however, my face will not be shown and my name or any personal information will not be disclosed

Patient's Printed Name_____ **Participant's Signature**_____

Date:_____

Witnessed by:_____ **Signed:**_____ **Date:**_____

OR

TO DECLINE PHOTOGRAPHY

☐ I have declined to take any photographs of the body parts that will be worked during my procedure, even though, the staff and physician have explained that they will only be used for my chart and follow ups.

☐ Therefore, I understand and agree that I will not be able to claim any type of touch-ups for any irregularities or defects after my procedure. Any type of change or modification or "touch-up" will be considered as a new procedure since we won't have any documentation where we can compare before and after results.

Patient's Printed Name_____ **Participant's Signature**_____

Date:_____

Witnessed by:_____ **Signed:**_____ **Date:**_____