

# CBCC *Comprehensive Blood & Cancer Center*

## Medical Oncology and Hematology

Ravi Patel, MD, FACP      David Kanamori, MD  
Alan D. Cartmell, MD, FACP      Richard Ng, MD, FACP  
Shane H. Tu, MD, FACP, FAGCS  
Shawn C. Shambaugh, MD  
Madan Mukhopadhyay, MD, FACP

## Radiation Oncology

Ajay Desai, MD  
Giridhar Gorla, MD  
Owen Kim, MD  
Infectious Disease  
Randolph Senining MD

## Pathology

Fangluo Liu, MD, FCAP  
Dermatology  
Neal M. Ammar, MD  
Mind-Body Medicine  
Naina Patel, MD

## Breast Center

James Watson, MD  
Peter H. Ashjian, MD  
Vipul R. Dev, MD

Date \_\_\_\_\_

Dear \_\_\_\_\_:

Thank you for considering Comprehensive Blood & Cancer Center (CBCC) for your medical care. Our goal is to provide you with the most advanced diagnostics and treatments available in the world. Our staff of physicians, nurses, therapists, and assistants are dedicated to delivering your care in the most professional and compassionate way possible.

Your appointment is scheduled for \_\_\_\_\_ at \_\_\_\_\_.

Enclosed with this letter are a number of items:

1. Directions to CBCC
2. Request for Release of Medical Records – Signature and Date of Birth only
3. Patient Information Form
4. Patient Financial Responsibility/Assignment of Benefits Form
5. CBCC Collection Policy
6. Release of Patient Medical Information Form
7. Patient Health and Medical History Questionnaire
8. Walk-in Procedure
9. Visitors, Children and Pregnant Women
10. Prescription Refill Policy

Please complete the required forms found on the right hand side of your packet and bring them with you to your scheduled appointment. If you have an Advanced Directive, please bring a copy for us to place in your medical records.

We understand that having an illness is difficult for you and your family. Our physicians and staff are sensitive to this and are dedicated to helping you.

When you arrive at CBCC, please sign-in with the receptionist. If for some reason you are unable to keep your scheduled appointment, please call as soon as possible to reschedule. This will allow us to use your time slot for another patient, and will permit you to receive the next earliest appointment time possible.

If you have questions, please call us at 661-322-2206.

Sincerely yours,

Physicians and Staff of CBCC

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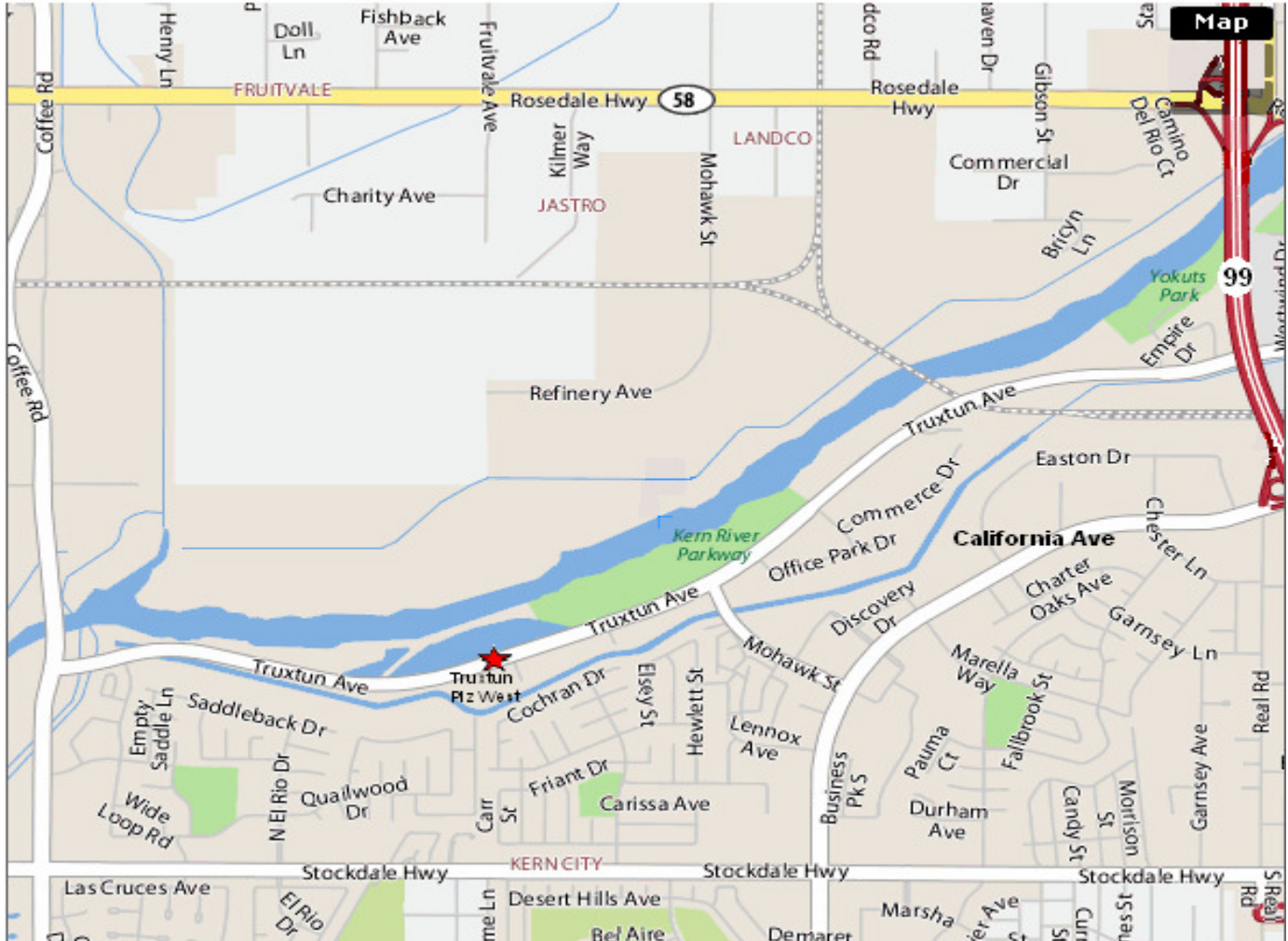
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## DIRECTIONS TO CBCC



We are located on the south side of Truxtun Avenue across the street from the Truxtun Lake, between Mohawk and Coffee Road.

From Highway 99 southbound, take the California Avenue exit, turn right on California Avenue, then right on Mohawk Street, turn left on Truxtun Avenue, then turn left on Truxtun Plaza West and turn right into the first parking lot. Our facility entrance is straight ahead by the Fountain of Life.

From Highway 99 northbound, take the California Avenue Exit, turn left on California Avenue, then right on Mohawk Street, then left on Truxtun Avenue, then left on Truxtun Plaza West and turn right into the first parking lot. Our facility entrance is straight ahead by the Fountain of Life.

**UCLA Affiliated Medical Center · Website: [www.cbccusa.com](http://www.cbccusa.com)  
6501 Truxtun Avenue · Bakersfield, CA 93309 · (661) 322-2206 · FAX 322-7027**



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## PATIENT INFORMATION FORM

Date \_\_\_\_\_

Name \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Work Telephone # \_\_\_\_\_

Occupation Present and Former  
 \_\_\_\_\_  
 \_\_\_\_\_

If Student, Name of School  
 \_\_\_\_\_  
 \_\_\_\_\_

Spouse or Responsible Party

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone # \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Spouse Employment \_\_\_\_\_  
 \_\_\_\_\_

Work Telephone # \_\_\_\_\_

If Retired, Former Employer \_\_\_\_\_  
 \_\_\_\_\_

Person to Contact in Case of Emergency

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Please bring your insurance card(s) and prescription card with you and present them to the Receptionist when you arrive for your appointment.**

To better meet our patients' needs we can dispense some of the prescriptions as prescribed by our physician(s). We will bill your pharmacy insurance and charge the applicable co-pay. Please understand that you are not obligated to have prescriptions filled here and you have the option of receiving your medications from the pharmacy of your choice. We would be happy to facilitate this for you.

\_\_\_\_\_  
 Patient's Name

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date Signed

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### **PATIENT FINANCIAL RESPONSIBILITY ASSIGNMENT OF BENEFITS**

Providing information about your insurance coverage is important. Comprehensive Blood & Cancer Center will make every effort to obtain authorization for the requested services from your Medicare and/or your private insurance company. We will also bill Medicare and/or your insurer for the services that we provide. By signing the Form you authorize the payment of insurance benefits to CBCC for the services provided to you.

By signing the form you also authorize the release of medical information to your insurance company and to any other physicians participating in your medical care.

Medicare and private insurance companies may not cover the services requested by your physician or they may only pay a portion of the amount that Comprehensive Blood & Cancer Center bills to them. For example, patients are typically responsible for paying deductibles, co-insurance, and co-payments. By signing the Form you acknowledge that you are responsible for the amounts not paid by Medicare and/or your insurance company. By signing you also agree to meet with the Comprehensive Blood & Cancer Center's Financial Counselor to arrange a payment plan for any outstanding balances. The counselor will work with you to make these payments as easy as possible on you and your family.

PET Scans: For patients receiving PET scans there is an additional obligation. Since the materials used in the PET scan must be specifically ordered for each patient, PET scans may only be cancelled up to 24 hours before the exam is scheduled. After this time period, patients canceling a PET scan will be charged a fee of \$250.00

Patient Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Print Patient Name \_\_\_\_\_

### **INSURANCE ELIGIBILITY CERTIFICATION**

I understand that it is my responsibility to provide the Comprehensive Blood & Cancer Center with accurate information regarding my Medical Insurance Coverage. Should there be any change in my coverage I agree that I am responsible to notify CBCC of the changes and understand that should I fail to do so, I will be financially responsible for any resulting unpaid claims.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**MANDATORY: THIS FORM MUST BE COMPLETED**

**RELEASE OF PATIENT MEDICAL INFORMATION**

I give the physicians and staff of Comprehensive Blood & Cancer Center (CBCC) permission to discuss my treatment, diagnostic tests, and medical condition with the following family members and friends:

1. I understand that if I wish individuals added or deleted from this list that I must notify CBCC in writing.
2. I understand that if my telephone or FAX number changes that I must notify CBCC in writing.

Release Information to: \_\_\_\_\_

Relationship

Phone #

Release Information to: \_\_\_\_\_

Relationship

Phone #

Release Information to: \_\_\_\_\_

Relationship

Phone #

Release Information to: \_\_\_\_\_

Relationship

Phone #

I authorize CBCC to leave test results on my voice mail:      Yes    No    (Circle one)

My telephone number's are:      \_\_\_\_\_      \_\_\_\_\_

I authorize CBCC to fax test results to me:      Yes    No    (Circle one)

My fax number is:      \_\_\_\_\_

**THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED.**

\_\_\_\_\_  
 Print Patient Name

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date Signed

# CBCC COLLECTION POLICY

*Effective May 1, 2005*

## CASH PAY:

- Payment in full is due at time services are rendered.
- Patient is requested to keep an authorized credit card on file. In the event that there is an unpaid balance at the time of monthly billing, this balance can be transferred to the credit card. A courtesy call will be made to the patient to arrange this transaction.
- Patients with financial hardship will be referred to the CBCC Social Worker to establish the level of need and provide available assistance.

## MEDICARE WITH NO SECONDARY INSURANCE:

- CBCC accepts Medicare assignment.
- Patient is responsible for payment of any deductible amount, 20% co-insurance and any non-covered services for which an Advanced Beneficiary Notice has been signed.
- Payment is due in full upon receipt of monthly statement.
- Patient is requested to keep an authorized credit card on file. In the event that a balance is delinquent for greater than 30 days, following a courtesy call, the balance can be transferred to the credit card.
- Patients with financial hardship will be referred to the CBCC Social Worker to establish the level of need and provide available assistance.

## MEDICARE WITH SECONDARY INSURANCE:

- CBCC accepts Medicare assignment
- Secondary insurance will be verified for coverage. If appropriate coverage exists, CBCC will bill the supplemental plan.
- All co-pays are due at the time of service.
- Patient is responsible for any balance unpaid by the supplemental plan and any non-covered services for which an Advanced Beneficiary Notice has been signed. This payment is due in full upon receipt of monthly statement.

## COMMERCIAL INSURANCE:

- Insurance plans will be verified for coverage. If appropriate coverage exists, CBCC will bill the plan(s).
- All co-pays are due at the time of service.
- Patient is responsible for any balance due after payment by insurance plan(s).
- Payment is due in full upon receipt of monthly statement.
- Patient is requested to keep an authorized credit on file. In the event that a balance is delinquent for greater than 30 days, following a courtesy call, the balance can be transferred to the credit card.
- Patients with financial hardship will be referred to the CBCC Social Worker to establish the level of need and provide available assistance.

## MEDI-CAL SHARE OF COST:

- Until the share of cost is met, the cash pay policy will be followed.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## PATIENT HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_

Personal Physician \_\_\_\_\_

Referring Physician (if different) \_\_\_\_\_

### ***INSTRUCTIONS***

Please answer carefully the enclosed questionnaire about your present and past medical problems and the history of your current illness. It is important that you complete each of the questions as accurately as possible so the doctor can best understand the nature of your present medical problems.

This information will become part of your permanent medical records and will remain confidential. The contents of this questionnaire will only be released with your written authorization.

Updated 6/16/09

## HISTORY OF PRESENT ILLNESS

Why did your doctor send you to CBCC for this consultation - chief complaint?

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Did you discover the medical problem? Yes  No

Did your doctor find it? Yes  No

Have you been treated for this problem? Yes  No

If yes, please give the date and location of the treatment/surgery:

Surgery:

Radiation:

Drug or other therapy (Chemotherapy):

Briefly describe your current medical problem. List symptoms and how long you have had them:

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Do you have other medical problems that are now being treated? Yes  No   
If yes, please list them here:

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### PAST MEDICAL HISTORY

Please circle the illnesses that you have had. Provide the year for those needing hospitalization:

___ Heart Disease	___ Scarlet Fever	___ Recurrent Pneumonia
___ Cancer	___ Hepatitis	___ Kidney Disease
___ Diabetes	___ Stomach Ulcer	___ Recurrent Bronchitis
___ Emphysema	___ Peptic Ulcer	___ Venereal Diseases
___ Hives	___ Liver Disease	___ Nervous Breakdown
___ Asthma	___ Jaundice	___ Bleeding Disorder
___ Tuberculosis	___ Measles	___ Rheumatic Fever
___ Valley Fever	___ Mumps	___ High Blood Pressure
___ Blood Clots	___ Chicken Pox	___ Shingles/Herpes Zoster
___ Seizures	___ Anemia	___ Any other serious illness

Have you had any of the surgeries listed below? Please circle and give the year:

Appendix _____	Artery _____	Heart Problems _____
Breast _____	Colon _____	Heart Surgery _____
Eyes _____	Gallbladder _____	Hernia Repair _____
Hip _____	Knee _____	Prostate Gland _____
Lung _____	Mastoids _____	Thyroid Gland _____
Ovary _____	Nose _____	Hemorrhoids _____
Kidney _____	Tubes Tied _____	Tonsil & Adenoids _____
Veins _____	Uterus _____	Dilatation & Curettage _____
Bone Marrow _____	Bladder _____	
Stomach _____	Any Other _____	

Have you ever had problems with anesthesia? Yes  No   
 If yes, please state type of problem:

Have you ever had a blood transfusion? Yes  No   
 If yes, Month \_\_\_\_\_ Year \_\_\_\_\_

Have you ever had a radiation treatment? Yes  No   
 If yes, what part(s) of the body?

Have you had serious accidents or injuries? Yes  No   
 If yes, please describe the accident or injury:

Please list the names of any Medications that you take regularly:

NAME	DOSE	INSTRUCTIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Would you like to have some of your prescriptions filled at our office?  
 Yes  No

Are you **ALLERGIC** to any medications? Yes  No  Unknown   
 If yes, please name the medications and type of **ALLERGY**:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL HABITS (FOR EVERYONE)**

Please list the jobs that you have held: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been exposed to any of the following?

Radiation                      Yes  No                       Insecticides    Yes  No   
Petroleum Products        Yes  No                       Benzene        Yes  No   
Industrial Toxins            Yes  No

Have you used tobacco?    Yes  No   
If yes, list amount and type: \_\_\_\_\_  
\_\_\_\_\_

Do you drink alcohol?    Yes  No   
If yes, list amount and type: \_\_\_\_\_  
\_\_\_\_\_

Have you been on a diet in the past?                      Yes  No   
If yes, list type of diet and the reason: \_\_\_\_\_  
\_\_\_\_\_

Have you ever used "street drugs" (cocaine, marijuana, LSD, etc.)  
Yes  No

**RELIGIOUS BELIEFS (OPTIONAL)**

Do you have a religious background?    Yes  No   
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you think your religious beliefs have or will play any important role in your illness and treatment?    Yes  No

Would you like a doctor, nurse, or other staff member to pray with you?  
Yes  No

**CANCER SCREENING**

Have you had any of the following screening tests? If yes, when and where?

<u>Type of Test</u>	<u>Yes</u>	<u>No</u>	<u>When</u>	<u>Where</u>
Mammogram	_____	_____	_____	_____
Pap Smear	_____	_____	_____	_____
Prostate Exam	_____	_____	_____	_____
PSA	_____	_____	_____	_____
Colon Exam	_____	_____	_____	_____
Skin Exam	_____	_____	_____	_____
Chest x-ray	_____	_____	_____	_____

Has any member of your family had cancer?    Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please see next page and list others here: \_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY FOR CANCERS

Place a check mark (√) in the boxes below for yourself and each family member who has had a cancer diagnosis as indicated.

Immediate Family Members	Breast Cancer Before Age 50	Breast Cancer After Age 50	Colon Cancer Before Age 50	Colon Cancer After Age 50	Endometrial Cancer Before Age 50	Endometrial Cancer After Age 50	Ovarian Cancer at Any Age	Other Cancers at Any Age List Type
Yourself								
Mother								
Father								
Sister(s)								
Brothers(s)								
Daughter(s)								
Son(s)								
<b>MOTHER'S SIDE</b>								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								
<b>FATHER'S SIDE</b>								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								

**Any males with breast cancer at any age.**

## FAMILY HISTORY – GENERAL

Please list the members of your immediate family, their ages, current health status, and if deceased, their cause of death.

Immediate Family Member	Age	Health Status			Cause of Death And Age
		Good	Fair	Poor	
Mother					
Father					
Sister(s)					
Brother(s)					
Daughter(s)					
Son(s)					

Has any family member had a blood disease? Yes  No   
 If yes, please list relationship and type of blood disease.

Do any of the following conditions run in your family?

Twins                      Yes  No   
 Birth defects            Yes  No   
 Tumors                    Yes  No

Are you a twin?            Yes  No

Were you born with a birth defect?    Yes  No     Please explain:

Additional comments:

## REVIEW OF SYSTEMS

Do you have, or have you had in the past 6 months, any of the following.  
Please **circle**.

General weakness  
Skin rashes  
Change in taste  
Sores not healing

Fever of unknown cause  
Weight loss without cause  
Enlarging moles

Night sweats  
Chills  
Loss of appetite

---

Do you have frequent/recurrent headaches?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have frequent dizzy spells?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever fainted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had a recent change in eyesight?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had recent change in hearing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have ringing or roaring in your ears?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you wear dentures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do they fit properly?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have frequent sore throats?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have trouble swallowing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have hoarseness without colds?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you lumps or swelling in the neck?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you cough up a lot of phlegm?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you coughed up blood?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have coughing spells?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you get short of breath without exercise?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
With exercise?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had pains in your chest?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been treated for heart problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had high blood pressure?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had thumping or racing heart?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do your ankles swell?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have frequent indigestion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have pain in your stomach?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had frequent nausea or vomiting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever vomited blood?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had black bowel movements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have your bowel movements changed in the last 6 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had blood in your bowel movements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you notice burning on urination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you get up every night to urinate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you passed blood in your urine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you passed a kidney stone?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had root beer colored urine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any change in your desire for sexual activity?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have you noticed any change in your ability to

engage in sexual activity?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have joint trouble?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have constant back pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have constant bone pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you bruise easily?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you bleed easily?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do your gums bleed frequently?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have prolonged bleeding with cuts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have frequent nosebleeds?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have feelings of sadness, depression, or anxiety?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**FOR MEN ONLY**

Do you have trouble urinating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been told you have prostate problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been circumcised?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**FOR WOMEN ONLY**

How old were you when you began menstruating? \_\_\_\_\_

How old were you when you first became pregnant? \_\_\_\_\_

Do you still have periods? Yes  No

If yes, please indicate date of last period: \_\_\_\_\_

If no, please list reason: Natural  Surgery

Have you ever taken birth control pills? Yes  No

Have you ever taken hormones? Yes  No

When was your last pap smear? \_\_\_\_\_

Do you bleed between your periods? Yes  No

Last mammogram: Date \_\_\_\_\_ Where? \_\_\_\_\_

Breast self exam? Yes  No

Nipple discharge? Yes  No

Palpable lumps? Yes  No

Change in size or shape of nipples/breast? Yes  No

Please indicate the following:

Number of pregnancies	_____	Number of cesareans	_____
-----------------------	-------	---------------------	-------

Number of miscarriages	_____	Number of stillborn	_____
------------------------	-------	---------------------	-------

Number of premature births	_____	Number of abortions	_____
----------------------------	-------	---------------------	-------

Number of children born alive	_____
-------------------------------	-------

Have you had any complications of pregnancy? Yes  No

\_\_\_\_\_  
\_\_\_\_\_

**FOR YOUR INFORMATION:**



*Comprehensive Blood & Cancer Center*

UCLA Affiliated Medical Center · Website: [www.cbccusa.com](http://www.cbccusa.com)

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UCLA Affiliated Medical Center  
Website: [www.cbccusa.com](http://www.cbccusa.com)

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## **CBCC POLICY ON APPOINTMENTS**

The CBCC staff focuses very hard on being respectful of your time. As such, we encourage you to keep all of your scheduled appointments.

The staff also understands that from time to time patients need immediate attention for the medical condition they are being treated for at CBCC. In such situations, please call us before coming to the facility, so that we can expedite the scheduling of your visit and limit your wait.

The Physicians and Staff of CBCC thank you for your cooperation.



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## **CBCC POLICY ON CHILDREN & VISITORS**

**EXPOSURE** – Pregnant women and growing children should not be exposed to chemotherapy drugs and radioactive agents.

**So PLEASE** – Pregnant women and no one under the **Age of 16 Years** is allowed in the restricted areas of CBCC

- Infusion Center - Chemotherapy
- Nuclear Medicine & Imaging Waiting Area

**VISITORS** – Space at CBCC is limited.

**So PLEASE** – do not bring more than 2 (two) people with you for your scheduled appointments. Also, please note that unattended children are not allowed in the Waiting Area of CBCC.

The Physicians and Staff of CBCC thank you for your cooperation.



*UCLA Affiliated Medical Center*  
Website: [www.cbccusa.com](http://www.cbccusa.com)

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6501 Truxtun Avenue · Bakersfield, CA 93309 · (661) 322-2206 · FAX 322-7027

## PRESCRIPTION REFILL POLICY

- To request a refill call your pharmacy 72 hours prior to your last dose.
- For outside prescriptions (prescriptions not filled by CBCC) your pharmacy will fax your request to CBCC's dedicated pharmacy fax.
- Please do not call CBCC, your physician's office will respond to the pharmacy fax.
- To change a prescription call CBCC and ask for your physician's office. Do not call your pharmacy.
- Leave a message with your name, date of birth and prescription request.
- If your request is approved the prescription will be faxed to your pharmacy. If it is not approved your physician's office will call you.
- Messages are checked every two hours – Please do not call back to inquire about your prescription.

## DEA SCHEDULE II DRUGS\*

- **Must be written on a Secure Rx form.** Limited to a 30 day supply with no refills.
- To request another 30 day supply or to request a change in your medication call CBCC at least 72 hours prior to your last dose and ask for your physician's office.
- Leave a message with your name, date of birth and prescription request. If someone other than you is picking up the prescription at CBCC, provide their name & a password which they will need to pick-up the Rx.
- Messages are checked every two hours – Please do not call back to inquire about the prescription.
- Call **Monday** & pick-up on **Thursday** ➤ Call **Tuesday** and pick-up on **Friday**
- Call **Wednesday** & pick-up on **Friday** ➤ Call **Thursday** and pick-up on **Monday**
- Call **Friday** & pick-up on **Tuesday**
- If your request is not approved your physician's office will call you.

## SCHEDULE II DRUGS

Codeine	Demerol	Dilaudid	Fentanyl
Hydrocodone	Morphine	MSContin	
Oxycodone	Oxycontin	Percocet	Methadone
Seconal	Thylox		Roxanol

# CBCC

*Comprehensive Blood & Cancer Center*

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## **REQUESTING MEDICAL RECORDS, FILMS, CDS, OR PHYSICIANS LETTERS**

For any medical records, imaging films or imaging CD's or physician letters please call 661.322.2206. For a copy of your mammogram, please contact the Breast Center 661.616.1643.

Please allow up to 48 hours for your request to be processed. In the event, that your request will take longer, CBCC will notify you.

We understand that sometimes records, copies of images and physician letters are need ASAP, and in these situations, we will do our best to accommodate your request.

The Physicians and Staff of CBCC thank you for your cooperation.