



Current Safety and Red-Flag Screening

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAHP

Patient Name: _____ Date of birth: ____/____/____

Today's Date: ____/____/____

PURPOSE OF THIS FORM

This screening is required before Dr. Weyrich begins a new patient-specific project and whenever requested before he continues or resumes substantive professional work during an ongoing relationship. It is intended to identify current symptoms, recent events, and background risks that may require clarification, immediate attention, contact with another clinician, urgent or emergency evaluation, or postponement of the requested service.

IMPORTANT - DO NOT WAIT FOR THIS FORM TO BE REVIEWED

If you are currently experiencing severe chest pain or pressure, severe difficulty breathing, signs of stroke, loss of consciousness, uncontrolled bleeding, a severe allergic reaction, or an immediate risk of harm to yourself or another person—or if possible stroke symptoms began recently but lasted only a few minutes or have since resolved—stop completing this form and call 911 or go to the nearest emergency department now.

This form is not continuously monitored, and submitting it does not mean that it has been reviewed. Do not use this form, email, text, voicemail, or portal messaging to report an urgent or emergency problem.

This is a limited safety screen, not a complete medical history, review of systems, physical examination, diagnosis, or medical clearance. Completion or review of this form does not guarantee that every urgent condition, diagnosis, or risk will be identified. **You remain responsible for promptly seeking appropriate local care for urgent, worsening, or emergency symptoms.**

CURRENT OR RECENT SYMPTOMS AND EVENTS

Have you experienced any of the following?

Consider:

- Symptoms or events happening now.
- If this is your first screening, symptoms or events during the past 30 days; otherwise symptoms or events since your last screening
- Older symptoms or events that remain active, unresolved, or relevant to your current safety.

Check every item that applies.

Emergency or potentially urgent symptoms

- ☐ Sudden drooping or numbness of the face; weakness or numbness of an arm or leg, especially on one side; sudden trouble speaking, understanding, seeing, walking, or coordinating; or a sudden severe unexplained headache?
- ☐ Chest pain, pressure, squeezing, tightness, or discomfort; pain spreading to an arm, the back, neck, jaw, or stomach; or chest symptoms with shortness of breath, sweating, nausea, dizziness, or fainting?
- ☐ A new sustained rapid or irregular heartbeat, especially with chest pain, shortness of breath, dizziness, near-fainting, or fainting?
- ☐ Severe or rapidly worsening shortness of breath; blue or gray lips or nail beds; inability to speak normally because of breathlessness; or coughing up blood?
- ☐ Swelling of the lips, tongue, face, or throat; hives with difficulty breathing or swallowing; wheezing; or fainting after a food, medication, supplement, sting, or other exposure?
- ☐ Loss of consciousness, a new seizure, inability to awaken normally, new severe confusion, or a major change in mental status?
- ☐ Thoughts, intent, or a plan to harm yourself or another person; feeling unable to stay safe; or inability to care for yourself or a dependent person?
- ☐ Uncontrolled or heavy bleeding; vomiting blood or material resembling coffee grounds; black or tarry stool; a large amount of blood in the stool or urine; or bleeding with dizziness or fainting?
- ☐ Sudden severe abdominal, pelvic, chest, or back pain; a rigid or very tender abdomen; persistent vomiting; inability to keep fluids down; or signs of severe dehydration?
- ☐ New loss of bladder or bowel control, numbness in the groin or saddle area, or new severe weakness in one or both legs?
- ☐ New pain, swelling, redness, or warmth in one leg, especially with chest pain, shortness of breath, coughing blood, or fainting?
- ☐ Fever, chills, or suspected infection with confusion, severe weakness, rapid breathing, clammy or sweaty skin, very little urine, or rapid worsening?

- ☐ Pregnancy or possible pregnancy with heavy bleeding, severe abdominal or pelvic pain, severe headache, vision changes, fainting, or another urgent concern?
- ☐ A possible medication, drug, supplement, chemical, or other poisoning or overdose?

Other significant recent changes

- ☐ A sudden or unexpected increase in any symptom?
- ☐ A fall, motor vehicle accident, head injury, or other trauma?
- ☐ Hospitalization, surgery, or an emergency-department or urgent-care visit?
- ☐ A new diagnosis or an abnormal test result that requires prompt follow-up?
- ☐ A medication, supplement, or therapy started, stopped, missed, or changed; a possible overdose; or a new adverse reaction?
- ☐ Increasing pain, numbness, tingling, weakness, altered sensation, gait difficulty, dizziness, vertigo, or loss of balance?
- ☐ A new or worsening headache, change in vision, double vision, eye pain, sudden hearing change, or ear drainage?
- ☐ A new or worsening cough, wheezing, throat pain, trouble swallowing, facial pain, or unusual sinus drainage?
- ☐ New or increasing swelling of the hands, ankles, feet, abdomen, or lymph nodes, or rapid unexplained weight gain?
- ☐ Painful urination, blood in the urine, markedly reduced urine, or new urinary incontinence?
- ☐ A major change in bowel habits, persistent vomiting or diarrhea, blood in the stool, black stool, or new bowel incontinence?
- ☐ Nipple retraction or discharge, a new breast lump or dimple, or unexpected vaginal bleeding?
- ☐ A new or worsening change in memory, attention, judgment, behavior, or mental clarity?
- ☐ Severe anxiety or panic, marked hopelessness, or another major mood or behavior change not reported above?
- ☐ Unexplained weight loss or gain, fever, chills, or increased night sweats?
- ☐ New or progressive pain that is severe, occurs at rest, or is worse at night?
- ☐ An animal, insect, or spider bite; sting; wound; or skin infection with spreading redness, swelling, pain, drainage, or fever?
- ☐ New pain, swelling, redness, drainage, malfunction, or concern involving a pacemaker, defibrillator, joint replacement, screw, plate, breast implant, or other implanted device?
- ☐ None of the above recent symptoms or events.

BACKGROUND FACTORS THAT MAY CHANGE URGENCY OR INTERPRETATION

Please check all that apply:

- ☐ I have previously had a severe allergic reaction or anaphylaxis.
- ☐ I have been diagnosed with cancer, or a clinician has told me that cancer is suspected.
- ☐ I have had an organ transplant, recent chemotherapy, or treatment with immunosuppressive medication.
- ☐ I currently take a blood thinner or have a diagnosed bleeding disorder.
- ☐ I have injected non-prescribed drugs.
- ☐ I have a pacemaker, defibrillator, joint replacement, surgical hardware, breast implant, or another implanted device.
- ☐ I am pregnant, could be pregnant, or have given birth within the past year, especially within the past six weeks.
- ☐ None of the above background factors apply.

DETAILS FOR EACH CHECKED ITEM

For each checked item, include the symptom or event, date or approximate onset, whether it is happening now, severity, what makes it better or worse, and any clinician, urgent-care, or emergency evaluation already obtained.

Current height: _____ **Current weight:** _____

KNOWN ALLERGIES OR SERIOUS REACTIONS

Include drugs, foods, supplements, environmental exposures, latex, and contrast agents.

OTHER INFORMATION DR. WEYRICH SHOULD KNOW

PATIENT OR REPRESENTATIVE ATTESTATION

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that a checked response may cause Dr. Weyrich to request clarification, recommend local evaluation, communicate with an appropriate treating clinician as permitted by law, or pause, postpone, limit, or decline the requested project or service.

Submission or review of this form does not by itself establish acceptance of a new Work Order or other service, and no recommendation or disposition is effective until it is communicated to me or my authorized representative. I will promptly report a material change that occurs before or during active professional work.

This form may not be reviewed immediately. Do not wait for a response to this form when urgent or emergency care may be needed.

The practice may acknowledge receipt of this form administratively. Submission does not mean that the form has received clinical review. If the information provided suggests a potentially urgent or clinically significant concern, Dr. Weyrich may request clarification, contact you or your authorized representative, recommend appropriate local evaluation, communicate with another treating clinician as permitted by law, or pause the requested project or service.

Before providing a substantive patient-specific response, the practice will confirm the patient's current physical location and a reliable callback number. Nonurgent patient-specific review will ordinarily be scheduled for a time when both the patient and Dr. Weyrich are physically located in Arizona, unless another arrangement has been specifically approved.

Patient name (printed): _____

Date of birth: ____/____/____

Legal guardian or authorized representative, if applicable (printed name):

Relationship to patient / authority to sign: _____

Signer is: ☐ Patient ☐ Legal guardian ☐ Authorized representative

Signature: _____ **Date:** ____/____/____

OFFICE USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE

Date/time received: _____ **Method received:** _____

Initial review by / role: _____ **Date/time:** _____

Disposition:

- ☐ No immediate action identified from the information provided; this is not medical clearance.
- ☐ Additional information or records requested.
- ☐ Patient or authorized representative contacted for clarification.
- ☐ Same-day contact with PCP or treating clinician recommended.
- ☐ Urgent-care evaluation recommended.
- ☐ Emergency-department evaluation or 911 recommended.
- ☐ Emergency contact or emergency services activated by the practice.
- ☐ Unable to reach patient; contact attempts documented.
- ☐ Patient or representative declined the recommended action.
- ☐ Work Order or professional services paused pending evaluation, records, or other resolution.
- ☐ Other: _____

Action communicated to: _____ **Method:** _____ **Date/time:** _____

Follow-up responsibility / due date: _____

Notes / action taken: _____

Final review and disposition by Dr. Weyrich:

Signature or initials: _____ **Date/time:** _____