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Dear Colleague:

Attached please find the Pathways, Inc. referral packet used to apply for admission to the Therapeutic Foster Care Program. Upon receipt of all referral data, our Referral Review Team will consider and determine the referred youth's eligibility for admission.

Please submit the information outlined on the attached checklist to the Therapeutic Foster Care Program at the following address:

Pathways Inc.
Therapeutic Foster Care Program
Attn: Cynthia Gee
33 Denison Parkway West
Corning, NY 14830

If I may be of assistance in the referral process, please do not hesitate to contact me.

Sincerely,

Cynthia Gee, LMHC
Therapeutic Foster Care Program Director
Phone: (607) 937-4519
Fax: (607) 937-3206
cgee@pathwaysforyou.org

Pathways, Inc. Therapeutic Foster Care Program
Program Philosophy and Primary Goals

It is our mission to provide quality care, treatment, and services to foster care children and youth with serious emotional disturbances and developmental disabilities and their families. We believe in providing an appropriate therapeutic milieu in the last restrictive, age and culturally appropriate environment. We are committed to providing a structured therapeutic environment to support the youth as he/she progresses through the rehabilitative process. We are committed to facilitating the development of the relationship between the youth and their family, by building on the child and family's strengths and assist them to develop the assets and skills needed.

The Therapeutic Foster Care Program is committed to effectively recruiting, training, and supporting our Resource Parents enabling them to provide intense support and care to youths participating in the program. We are committed to the provision of guidance and training in structured daily living and socialization/recreational activities to foster the youths' acquisition of skills necessary to perform activities of daily living and the development of age appropriate social and interpersonal skills. Behavior management training and counseling services assist the youth in developing problem solving and coping skills while supporting the reinforcement and generalization of newly-learned positive behaviors to school, home, and other community settings. We are committed to the flexibility and creativity necessary to meet each youth's unique needs and collaborate with community-based services to individually tailor our treatment approaches. Family members of the youths are embraced as an integral part of the service planning and encouraged to participate in their child's treatment and care. We are committed to offering families with education/information, emotional support, skill development, and linkage to family support programs and services. We believe in supporting each family in its effort to enhance its relationship with the child and/or resume primary care for the child. The Therapeutic Foster Care Program believes in developing full partnerships with families, being safe, nurturing and therapeutic, ensuring individualized and comprehensive services that are creative and effective, striving to be culturally competent in all aspects of programming, using strength-based interventions, communications and practice, using interventions that create the possibility for each youth to reach his/her self-defined potential, being short-termed and community integrated, using the industries best practices, and employing trauma-sensitive practices.

Pathways, Inc.
Therapeutic Foster Care Program
Admission Criteria

The admission criteria for the Pathways, Inc. Therapeutic Foster Care Program include that the foster care youth must meet at least one of the following criteria:

1. have been diagnosed by a qualified psychiatrist or psychologist as being moderately developmentally disabled, emotionally disturbed, or having a behavioral disorder to the extent that they require a high degree of supervision (special foster care services); or

2. are awaiting family court hearings on PINS or juvenile delinquency petitions, or have been adjudicated as PINS or juvenile delinquents (special foster care services); or

3. enter foster care directly from inpatient hospital care (special foster care services); or

4. have severe behavior problems characterized by the infliction of violence on themselves, other persons or their physical surroundings, who have been certified by a qualified psychiatrist or psychologist as requiring high levels of individual supervision in the home (exceptional foster care services); or

5. have been diagnosed by a qualified physician as having severe mental illnesses, such as child schizophrenia (exceptional foster care services);

6. be a sibling of a youth in care that qualifies for special or exceptional foster care services;

The admission criteria for the Pathways, Inc. Therapeutic Foster Care Program include that the youth must meet all of the following criteria:

1. Be under the age of 21;

2. a measured IQ above 50;

3. demonstrated ability and willingness to participate in school or other day programming(except for nonschool age youth);

4. he/she must have the potential of functioning in the community, not needing the restrictiveness of a campus or facility-type environment.

5. he/she will require individualized, intensive treatment and rehabilitation services and usually exhibit a range of mental health and developmental diagnoses and characteristics (except for non-TFC level sibling);

6. demonstrated capability of self-preservation, as evidenced by successful completion of a Standard Capability of Self-Preservation Test.

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REFERRAL CHECKLIST

To consider your referral the following information must accompany this packet. Although the information requested is considerable, it is essential in determining the degree of the child's impairment and his/her potential to succeed in a community-based program. All assessments must have occurred within the last 90 days, except for the educational assessment, which must have occurred within the last year:

- □ Referral Form
- □ Initial and Current Family Assessment and Service Plan
- □ Current Court Order- including any visitation orders
- □ Psychiatric Evaluation (if available)
- □ Psychological Evaluation (if available)
- □ Educational Assessment/Current Academic Progress Report/ IEP
- □ Current Physical/Medical Assessment
- □ Consents for Release of Information
- □ HIPAA Consent
- □ Copy of Birth Certificate
- □ Copy of Social Security Card
- □ Copy of Insurance or Medicaid Card
- □ Health Intake Form

If I may be of assistance with this referral process, please do not hesitate to contact me at (607) 937-4519 or cgee@pathwaysforyou.org.

Cynthia Gee, LMHC
Pathways, Inc. Therapeutic Foster Care Program Director

Pathways Inc. Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Pathways Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to provide health care services.

I understand that diagnosis or treatment of me by Pathways Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of Pathways Inc. Pathways Inc. is not required to agree to a restriction that I request. However, if Pathways Inc. agrees to a restriction that I request the restriction is binding.

I have the right to revoke this consent, in writing, at any time.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Pathways Inc. Notice of Privacy Practices prior to signing this document.

The Pathways Inc. Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care services by Pathways Inc.

The Notice of Privacy Practices for Pathways Inc. is also provided at all program sites and on the Pathways Inc. web site at Pathwaysinconline.org.

This Notice of Privacy Practices also describes my rights and the duties of Pathways Inc. with respect to my protected health information.

Pathways Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Pathways Inc. web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Consumer or Consumer's Representative Date

_____

Name of Consumer or Consumer's Representative

_____

Description of Consumer's Representative's Authority

4/03 JC HIPAA Form C

PATHWAYS INC. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Pathways Inc. Privacy Officer at 607-937-3200 or in writing to 33 Denison Parkway West, Corning New York 14830.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at Pathways Inc.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel at Pathways Inc. may share information about you and disclose information to people who do not work at Pathways Inc. in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work, ordering x-rays, and scheduling other assessments. Family members and other health care providers may be part of your medical care outside Pathways Inc. and may require information about you that we have.

For Payment We may use and disclose health information about you so that the treatment and services you receive at Pathways Inc. may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to operate Pathways Inc. and make sure that you and our other consumers receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our consumers to help us decide what additional services we should offer, how we can become more efficient, or whether certain new services are effective.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures, which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we will therefore not be able to provide you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law.

Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Pathways Inc. Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend If you believe health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Pathways Inc. Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Pathways Inc. Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

We are Not Required to Agree to Your Request If we do agree; we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to the Pathways Inc. Privacy Officer.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Pathways Inc. Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice at all program sites with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Pathways Inc. Privacy Officer at 607-937-3200 or in writing to 33 Denison Parkway West, Corning New York 14830. You will not be penalized for filing a complaint.

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AUTHORIZATION FOR RELEASE OF INFORMATION	Name: Sex: M / F Date Of Birth:

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Purpose or Need for Information:

1. This information is being requested:
   - □ by the individual or his/her personal representative; or
   - □ Other (please describe) _____
2. The purpose of the disclosure is (please describe):

TO FACILITATE ONGOING EVALUATION AND TREATMENT

To/From: Name, Address, & Title of Person / Organization/Facility/Program Disclosing Information	To/From: Name, Address, & Title of Person/Organization/ Facility / Program to Which this Disclosure is to be Made NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.
_____ _____ _____	_____ _____ _____

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/ Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and can not legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program) _____
   I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the _____.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR *S*164.524).

B-1. One – Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.

My authorization will expire:
- □ When acted upon;
- □ 90 Days fro this Date;
- □ Other _____

Continue on Next Page

Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C"/Id. No.

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:
□ When I am no longer receiving services from (insert name of facility/program) _____
□ One Year from this date:
□ Other _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

_____ _____
LDSS Representative Date

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided To: _____

Date: _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/ Program whose name and address is:

_____
_____

I hereby refuse to authorize the use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is: _____
_____

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

_____ _____
LDSS Representative Date

PATHWAYS, INC.
THERAPEUTIC FOSTER CARE PROGRAM
REFERAL/DATA FORM

YOUTH INFORMATION

Youth's Name:_____

(Last) (First) (Middle)

Current Placement (Agency or Person):_____

Placement Address:_____

(Street) (City) (State) (Zip Code) (County)

Telephone Number (Including area code):_____

Date of Birth:_____ Birth Gender:_____ Ethnicity:_____

Name of Party Holding Custody:_____

Custodian's Address:_____

(Street) (City) (State) (Zip Code) (County)

Home Phone:_____ Business Phone:_____

REFERRAL SOURCE

Name of Referral Agent:_____

Title/Relationship to Youth:_____

Referral Agency:_____

Address:_____

(Street) (City) (State) (Zip Code) (County)

Telephone Number (Including area code):_____

Reason for Referral:_____

_____

Reason for Placement in LDSS Custody (Abuse/Neglect, JD/PINS, Voluntary, Surrender):_

_____

_____

Date of Probable Placement:_____

Projected Length of Stay:_____

Are the youth and family aware of and agreeable to this referral?

Yes:_____ No:_____

Please elaborate:_____

_____

Please list other facilities/programs to which the youth has been referred:_____

_____

Please note any other agencies currently involved with the youth and/or family: _____

_____

What is the current permanency planning goal for this youth?_____

_____

FAMILY INFORMATION

Mother's Name:_____ Date of Birth:_____

Address:_____ Telephone:_____

_____

Place of Employment:_____ Telephone:_____

Work Address:_____

Marital Status:_____

Father's Name:_____ Date of Birth:_____

Address:_____ Telephone:_____

_____

Place of Employment:_____ Telephone:_____

Work Address:_____

Marital Status:_____

Siblings:

NAME	AGE	IN LDSS CUSTODY?	PLACEMENT/ADDRESS	SCHOOL/GRADE

Name(s) of step parent(s) or other significant parental figure(s), if any, and date(s) of birth:

_____

_____

Name(s) of any permanency resources?_____

_____

Please note any significant family history (i.e.: physical abuse, sexual abuse, substance issue, mental illness, imprisonment, etc.):_____

_____

Youth and/or Family's religious preference: _____

Recommended visitation and phone contacts (duration/frequency and with whom): _____

_____

_____

Supervised: Yes No

Does the youth/family currently have any upcoming court appointments: Yes No

If Yes please state where and when:_____

Is the child a parent? Yes No

If yes, where is the baby placed (location and custody) and are there any CPS concerns?

_____

YOUTH'S PLACEMENT HISTORY

Psychiatric Hospitalizations:

FACILITY	DATES	THERAPIST/ PSYCHIATRIST	REASON FOR HOSPITALIZATION

Other Placements: Please list previous placements including RTC, RTF, Group Home, OMH Community Residence, Foster Care, etc.

FACILITY/PROGRAM	DATES	THERAPIST/ PSYCHIATRIST	REASON FOR PLACEMENT

YOUTH'S MENTAL HEALTH INFORMATION

Most Recent Psychiatric Diagnosis (DSM IV- TR):

Axis I: _____

_____

_____

Axis II: _____

Axis III: _____

Axis IV: _____

_____

Axis V: _____

Diagnosed by (name and title): _____ Date of Dx: _____

Current Therapist: _____ Telephone: _____

Agency/Facility Name: _____

Agency Address: _____

(Street) (City) (State) (Zip Code) (County)

Current Psychiatrist: _____ Telephone: _____

Agency/Facility Name: _____

Agency Address: _____

(Street) (City) (State) (Zip Code) (County)

Does the Youth Have a History of:

	Yes	Date & Description of Most Recent Incident	No	Unknown
Fire Setting				
Sexual Perpetration				
Sexual Victimization				
Sexualized Behaviors				
Verbal Aggression				
Physical Aggression				
Suicidal: Ideation				
Gestures				
Attempts				
Other Self-Harm				
Homicidal: Threats				
Gestures				
Substance Abuse				
Criminal Activities				
Legal Adjudication (s)				

Other Behaviors (please describe): _____

_____

Youth's Assets: _____

_____

Youth's Liabilities: _____

_____

Does the youth currently have any upcoming therapy/psychiatric appointments: Yes No

If Yes please state where and when:_____

YOUTH'S MEDICAL INFORMATION

Physician:_____ Telephone:_____

Address:_____

(Street) (City) (State) (Zip Code) (County)

Date of Most Recent Physical:_____

Describe Any Ongoing Medical Needs/Concerns (Allergies/Sensitivities):_____

_____

_____

Dentist:_____ Telephone:_____

Address:_____

(Street) (City) (State) (Zip Code) (County)

Date of Most Recent Dental Exam: _____

Prescribed Medications:

Medication	Dosage	Schedule	PRN? Yes	No	Purpose

Does the youth currently have any upcoming medical appointments: Yes No

If Yes please state where and when:_____

Special Needs (ie. Bedwetting; medical concerns; physical, unusual behaviors,etc.): _____

_____

_____

YOUTH'S EDUCATIONAL INFORMATION

School Name:_____ Grade:_____

Address:_____

(Street) (City) (State) (Zip Code) (County)

School Counselor:_____ Telephone:_____

Current Educational Placement:

Regular Ed. _____ Option Program _____ Day Tx. _____

Educational Classification:_____

Does the youth have a current IEP: Yes No

IQ Test Results (if available):

Full Scale:_____ Performance:_____ Verbal:_____

Date Tested:_____ Test Administered:_____

Test Administered by:_____ Title:_____

Referral Submitted by:

_____

LDSS Representative Signature Date

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HEALTH INTAKE FORM

Youth Name_____ Completed by_____

Date of Birth_____ Date Completed_____

A. YOUTH DESCRIPTION:
Gender_____ Race _____ Height_____ft____inches__
Weight _____ Eyes_____ Hair _____

Physical characteristics (scars, identifying marks, pierced ears, etc.):_____
_____

B. PROVIDERS/RECORDS:
1. Primary care provider _____
(Name) (Address)

2. Specialty care provider_____
(Name) (Address)

3. Dentist_____
(Name) (Address)

4. Last physical:_____
(Date) (Where/by Whom)

5. Health records:
Present?_____yes If present, where?_____
____no if not present, sent for?_____Yes- by whom?_____
Date requested_____

C. CHILD'S MEDICAID #_____
Is there a health insurance plan that covers this child? _____Yes _____No
If yes, is this coverage for this child expected to continue? _____Yes _____No
If yes, policy name and contract #_____

D. SIGNIFICANT FAMILY HEALTH HISTORY:
Mother_____
_____

Father_____
_____

Siblings_____
_____

Extended family_____
_____

E. HEALTH HISTORY

Problem/Issue			If yes, provide explanation or comment
Problem pregnancy	___yes	___no	
Problem delivery	___yes	___no	birth weight:
Problem walking	___yes	___no	age:
Problem talking	___yes	___no	age:
Problem toilet training	___yes	___no	age:
Major illness	___yes	___no	
Operations	___yes	___no	
Head injuries	___yes	___no	
Seizures (History)	___yes	___no	
Other hospitalizations	___yes	___no	
Prone to strep throat	___yes	___no	
Prone to ear aches	___yes	___no	

F. DISEASES (state diseases child has had and age when they developed)

Infections (chicken pox, diphtheria, measles, mumps, whooping cough, typhoid, meningitis, encephalitis, syphilis, gonorrhea, poliomyelitis, scarlet fever, etc.)

Other (convulsions, diabetes, rheumatic fever, chorea, rickets, kidney disturbances, etc.)

G. IMMUNIZATIONS

DATES RECEIVED

	#1	#2	#3	Booster	Booster
Diphtheria-Pertussis-Tetanus					
Oral Polio Vaccine Trivalent					

DATES RECEIVED

Tetanus-Diphtheria (Td)		
Mumps, Measles, Rubella		

H. CURRENT HEALTH ISSUES

Food allergies	___yes ___no	what? _____ Reactions: _____
Pet allergies	___yes ___no	what? _____ Reactions: _____
Bee sting reactions (life threatening)	___yes ___no	what? _____ Reactions: _____
Medication allergies	___yes ___no	what? _____ Reactions: _____
Other allergies	___yes ___no	what? _____ Reactions: _____
Diabetes	___yes ___no	_____
Hepatitis B carrier	___yes ___no	_____
Seizures (current)	___yes ___no	_____
Enuresis (bedwetting)	___yes ___no	_____
Encopresis (soiling)	___yes ___no	_____
Dental problems	___yes ___no	_____
Wears glasses	___yes ___no	_____
Sexually active	___yes ___no	_____
Ever used contraception	___yes ___no	what: _____
Ever had any venereal disease	___yes ___no	_____
Alcohol use	___yes ___no	_____
Tobacco use	___yes ___no	_____
Menstruation	___yes ___no	started when? _____ last period when? _____
Pregnant now	___yes ___no	_____

I. MEDICATION

1. Is the child on any medication right now? ___yes ___no
   If yes: Drug use and dosage _____
   Has the child been taking this regularly? _____
   Prescribing doctor _____
   Do you have a follow-up appointment? _____ When? _____
   If not, when is the child due to return? _____
2. If more than one medication, give same information below for each medication.

_____

_____

3. Besides above, has the child been on other psychotropic medication in the past?
___yes
___no

If yes, what medication and what response?

J. NOTES: Use this section if more space is needed, or to cover any other health issue not covered elsewhere.