Parkside
Psychiatric Hospital & Clinic

INFORMED CONSENT FOR TREATMENT

Patient Label

TREATMENT:
I, the undersigned patient, both personally or through the person legally empowered to sign this consent and obligate me as herein contemplated, request and authorize Parkside, Inc., its employees, agents, affiliates (jointly and separately), and physicians to provide hospital care (acute care, residential care, or any of the outpatient programs), upon admission therein, including without limitation, physical examination, routine diagnostic procedures and medical or psychological treatment which is to include whatever procedures that are deemed necessary by the admitting physician and such other physician, assistants, students, or volunteers as s/he may designate.

I summarily request and authorize Parkside, Inc. and physician(s) to administer any treatment and perform such other actions as the physician may deem necessary or advisable in the diagnosis and treatment of my illness. If indicated or requested, and with proper written consent, testing for communicable diseases will be performed on physician order.

I am aware that the practice of medicine is not an exact science and acknowledge that no warranty, guarantee or assurance has been made thereto by hospital and/or physician as to the result of treatments, examinations or otherwise that may be obtained.

RESTRAINT, SECLUSION, PHYSICIAL HOLDS AND TIME OUTS:
Parkside, Inc. reserves the right to restrain, seclude or physically hold any patient clinically determined to be a risk to him/herself or others. Restraints, seclusions and physical holds are performed by physician order consistent with hospital policy and procedure. A patient may request to take a time out or may be asked by a staff member to take a time out if he/she is disrupting the milieu or needs time to regain control of his/her behavior. Time outs do not require a physician's order and may not exceed thirty (30) minutes duration.

CONFIDENTIALITY & DISCLOSURE OF INFORMATION:
Parkside, Inc. will honor and respect my protected health information rights according to state and federal laws and the *Notice of Privacy Practices.* I understand that my medical records and billing information are made and retained by Parkside, Inc. and are accessible to hospital personnel and medical staff. Hospital personnel and physicians in attendance may use and disclose medical information for hospital operations and functions to any other physician or health care personnel involved in my continuum of care for this admission. Safeguards are in place to discourage improper access. Parkside, Inc. and its medical staff are authorized to disclose all or part of my medical record to any insurance provider who is or may become involved with my care. Oklahoma law requires that Parkside, Inc. advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphills, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). Communicable diseases will be released to health authorities as required by law.

FINANCIAL RESPONSIBILITY:
1. As consideration for the services provided me, payment is guaranteed for any amount due for such services provided by Parkside, Inc. Hospital charges for services and goods shall be at Parkside, Inc.'s billed charges rates unless otherwise agreed to in writing by Parkside, Inc. Amounts estimated or known to be payable by me become due and payable at the time of discharge including, but not limited to, health insurance deductible and coinsurance amount(s).
2. I understand that Parkside, Inc. will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment. I understand that any requirement for completion of insurance precertification is the responsibility of the policyholder.
3. I agree that insurance benefits for Parkside, Inc. charges payable to the insured are to be made payable to Parkside, Inc. and that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. I understand that I am responsible for any charges not covered by this assignment. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.
4. I agree to comply with all hospital rules and regulations and to participate in the treatment program as prescribed. I agree to reimburse Parkside, Inc. for any damage to the facility or personal property that I may cause or a patient for whom I am legal guardian my cause during the course of treatment.

PERSONAL BELONGINGS & RELEASE OF RESPONSIBILITY:

1. Parkside, Inc. is hereby released from any responsibility for personal property I do not provide to it for safekeeping.
2. I acknowledge that Parkside, Inc., or employees thereof, shall not be responsible for any personal valuables or belongings including, but not limited to, glasses, dentures, hearing or other prosthetic devices retained on my person or left in any room during my treatment.
3. Parkside Inc. is held harmless from any injuries, damages, claims or actions that may arise out of my use of personal equipment.

INPATIENT TREATMENT ONLY:

1. I consent to observation and diagnosis for inpatient hospital evaluation and treatment. Care and treatment includes, but not limited to, routine laboratory procedures, diagnostic procedures, body checks, evaluations done by nurses, social workers, psychologists, activity therapist and medical treatment rendered by my physician(s).
2. I understand that if the inpatient treatment team determines that I have a substance abuse/dependence problem requiring treatment, I may be required to remain on the unit for all treatment. Visitation may be restricted for a period of time. Any restrictions will be reviewed daily by the inpatient treatment team. The purpose for these requirements is for medical stabilization and prevention of further access to substances that may be abused.
3. I understand I can ask to leave at any time after I am admitted; however, if I should choose to leave inpatient treatment Against Medical Advice (AMA), it is my intention to give the staff a written notice 48 hours prior to the time I actually leave the hospital. If it is determined by my physician that I do not pose a danger to myself or others but my physician determines that I need to stay to complete my treatment, and I disagree with that opinion, I will be discharged Against Medical Advice. If I am discharged AMA, I understand that I will not be provided with prescriptions or any outpatient follow-up treatment.
4. **I understand that if my physician determines that my discharge might pose a danger to myself or others, I may be detained for up to three (3) business days during which my physician will initiate an involuntary commitment procedure for acute care.
5. I understand that should my conduct become disruptive or dangerous to myself or to others, the physician may order treatment with medication, seclusion, or restraint as needed.
6. I understand that I have the fundamental right to control decisions relating to the rendering of health care including the decision to have all life-sustaining procedures withheld or withdrawn in instances of terminal condition, and explaining these rights.

INPATIENT AND OUTPATIENT TREATMENT:

1. I consent to participate in the development and implementation of the treatment plan, and I understand that such treatment includes, but is not limited to: individual, group, marital, and family conferences, recreational activities and outings, and medical treatment which may be deemed necessary or advisable during my course of treatment.
2. I have been informed of my condition, problems related to recovery and likelihood of success.
3. I have been informed of proposed interventions, treatments and medications and the potential benefits, risks and side effects to each.
4. I have been informed of alternative interventions, treatments, medications and my right to refuse such to the extent permitted by law.
5. I recognize that Parkside, Inc. is a teaching facility and consent to the presence of student observers and treatment by supervised resident physicians.
6. I understand that my medical records may be reviewed by outside auditors such as Medicare/Medicaid, private insurance companies, the Joint Commission for Accreditation of Healthcare organizations and the Oklahoma State Dept. of Health.
7. I understand and authorize the review and/or release of information of my medical records to contacting agencies for services rendered and continued treatment as outlined in the Notice of Privacy Practices.
8. ** I have been provided with information regarding the transmission of the AIDS virus, behaviors that can place other and me at risk and information on how to obtain HIV testing, if needed.
9. ** I understand that in entering treatment, I must conduct myself in such a way as to protect myself from exposure to or transmission of Infectious diseases such as AIDS, hepatitis, venereal disease, and any other communicable disease.
10. ** I acknowledge that I have received information about tuberculosis including: Symptoms of TB, how TB is spread, and the risk factors for TB and how to obtain a test for TB. I have been given an opportunity to have my questions answered.

** I have received copies of the following: Patient and Client Rights, Patient and Client Responsibilities, Patient and Client Appeal Process, and client handbook (which explains hospital rules). As part of my treatment, there may be trips made outside of the hospital and volunteers may be used on occasion.

CERTIFICATION:
I hereby certify that I have read the contents of this form and have had the opportunity to ask any questions and obtain explanations to my satisfaction. I certify that I understand its content and significance. I further certify that all information requested during my evaluation is correct to the best of my knowledge. False information or information withheld could result in transfer or discharge.

If voluntarily admitted inpatient or outpatient, I understand that I am voluntarily consenting to treatment by Parkside, Inc. clinical staff.

Signature of Patient/Client _____ Date _____ Signature of Staff _____ Date _____

Signature of guardian or legal representative _____ Date _____
Note: If patient has a guardian or representative, that person must sign.

If patient is unable to consent and has no guardian/legal representative, complete below:
Patient is unable to give consent because: _____

If the patient is unable to comprehend his/her rights, a copy of the Mental Health Patients' Bill of Rights and Responsibilities and information regarding Advance Directive will be given or mailed to the person listed below within 24 hours of admission. Print name and address:

Name: _____

Address: _____

CONSENT FOR FOLLOW-UP

I (circle one) **Agree** **Do Not agree** to be contacted after treatment has ceased so that Parkside, Inc. may determined outcomes of any satisfaction I may have had with services received. (If I choose to exercise my right for Confidential Communications, as covered in the Notice of Privacy Practices, I will request the appropriate form.)

Signature of Patient/Client _____ Date _____ Signature of Staff _____ Date _____

Signature of guardian or authorized legal representative _____ Date _____

Parkside
Psychiatric Hospital & Clinic

NOTIFICATION OF LEGAL RIGHTS

Patient Label

Pursuant to Oklahoma Statute Title 43A, Section 5-505

I understand that I have been admitted for inpatient mental health treatment, and that a qualified mental health professional deems the admission to be appropriate.

I understand that my parent, guardian, or that I (if I am 16 years of age or older) may object to this admission and request a court hearing. The facility must assist me in filing the objection by providing written notification to the court without delay. A form to be completed will be provided to me that will object to this admission.

I understand that if an objection is filed, that I will continue to be involved in the treatment program while awaiting the court hearing and until such time as I have been given an opinion for the court.

Patient Name		MRN
Signature of Parent /Guardian	Signature of Patient if 16 years of age or older.	Witness
Date		Date

Parkside
Psychiatric Hospital & Clinic

Notice of Policy on Seclusion and Restraint Use – Child & Adolescent Units

Patient Label

PATIENT NAME: _____ **PATIENT ID#** _____

POLICY ON SECLUSION AND RESTRAINT USE

RECEIPT ACKNOWLEDGEMENT

Parkside utilizes Seclusion and/or Restraint as a means of protecting the patient's health and safety while preserving his/her rights, dignity, and well-being and those of other patients and staff. Physical, mechanical, and/or chemical restraints may be used.

Seclusion and/or Restraint is utilized as a last intervention when other less restrictive measures have been considered and rejected OR have been tried and failed.

I acknowledge receiving a copy of Parkside's policy on the use of Seclusion and Restraint.

I understand this policy.

Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

As the patient, I acknowledge receiving a copy of Parkside's policy on the use of Seclusion and Restraint. I understand this policy.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Parkside
Psychiatric Hospital & Clinic

GRIEVANCE AND PROBLEM RESOLUTION PROCESS

Patient Label

PURPOSE:
The purpose of this process is to ensure fair consideration of a complaint / grievance made by or on behalf of minor patients in the care of Tulsa Center for Adolescent Treatment of Parkside, Inc.

PROCEDURE:
When a patient or their parent / legal guardian has a complaint or grievance related to his/her treatment or care as a patient in our services, the process is as follows:

THE PATIENT OR PARENT / LEGAL GUARDIAN WILL:

1. Request a "Grievance and Resolution Process" form from any staff member.

2. Describe his / her complaint on the form and include suggested resolution. (If the patient is unable to write or read adequately, the staff will assist the patient with this process).

3. Sign the completed form and submit to any staff on duty.

4. A designated staff member will document in detail what steps were taken to resolve the grievance. This will be done within 24 hours of receiving the written "Grievance and Problem Resolution Process" form from the patient.

5. If the first staff member is unable to resolve the issue, the patient's therapist will address the concern and document the steps used to resolve the matter.

6. If the patient's therapist is unable to resolve the issue, the Program Director will address the concern and document the steps used to resolve the matter.

7. The "Grievance and Problem Resolution Process" form will be maintained by the Program Director on the unit.

If the patient or parent / guardian feel the problem has not been resolved to their satisfaction, they may contact the State of Oklahoma Department of Human Services Office of Client Advocacy at P.O. Box 25352, Oklahoma City, OK 73125, or by calling (405) 525-4850.

Patients or parents / legal guardian may also call or write the Oklahoma State Department of Health at 1000 N.E. 10th, Oklahoma City, OK 73125 or by calling (405) 271-6576.

I acknowledge that the contents of this form were explained to me on _____
Date

_____
Signature of Staff who explained the process

_____ _____ _____ _____
Patient Signature Date Parent / Guardian Signature Date

Parkside
Psychiatric Hospital & Clinic

CONSENT FOR TREATMENT ANIMAL BASED / ENHANCED THERAPY

Patient Label

I agree to participate or allow my child/ward to participate in Animal Based Therapy / Animal Enhanced Therapy. I understand that animal enhanced therapy involves the use of animals to aid in treatment. I understand that the animal is groomed, vaccinated, well behaved, and disease free. I understand that the therapist is always present and active in therapy. I understand that the therapist will control the use of animals and that any animal contact is closely monitored. I understand that Parkside Inc. is not liable for any physical injury during the course of therapy. I understand that I am not liable for any physical injury or damage to the animal in the course of therapy.

Patient Name (Print)	MRN
Patient / Parent / Guardian Signature	Date
Witness Signature	Date

Parkside
Psychiatric Hospital & Clinic

CONSENT FORM

Patient Label

CONSENT TO PHOTOGRAPH

I authorize one photograph for the purpose of identification during treatment at Parkside. I understand that this photograph becomes a part of the permanent confidential patient record. Prints or negatives of this photograph will not be used without my written consent for any other purpose.

APPROVAL: YES_____ NO_____ INITIAL_____

CONSENT FOR OFF-GROUNDS ACTIVITIES

I release Parkside from any liability incurred while participating in any therapeutic activity or staff-approved and supervised activity. I understand that these activities may include but are not limited to bowling, swimming, miniature golf, skating, movies, shopping, community events, zoo, museums, ball games, picnics, hiking, theaters, restaurants, and parks. Off-ground activities may also include community service projects such as visits to nursing homes.

APPROVAL: YES_____ NO_____ INITIAL_____

CONSENT FOR EDUCATION RE: STDS/PREGNANCY PREVENTION

I am aware that education will be provided regarding the prevention of pregnancy and the transmission of sexually. transmitted diseases.

APPROVAL: YES_____ NO_____ INITIAL_____

CONSENT TO REFRAIN FROM LEAVING AGAINST MEDICAL ADVICE

I understand that entering a treatment program for mental, emotional, or chemical dependency problems is stressful and can produce feelings of restlessness and irritability as well as physical discomfort. Because of this, there may be times when I want to leave the program. I understand that this is a common reaction and that my feelings of discomfort will dissipate in time. I therefore agree to stay 48 hours past the time I want to leave and to share these feelings with my primary therapist before leaving.

APPROVAL: YES_____ NO_____ INITIAL_____

CONSENT FOR HAIRCUT AND PERSONAL GROOMING EDUCATION

I authorize a haircut or hairstyle consultation if necessary and to participation in personal grooming and hygiene education.

APPROVAL: YES_____ NO_____ INITIAL_____

CONSENT FOR IMMUNIZATION ADMINISTRATION

I authorize Parkside to administer immunizations in accordance with the recommendations of the Department of Public Health.

APPROVAL: YES_____ NO_____ INITIAL_____

CONSENT FOR SCOUTS (Children')

I authorize Parkside to enroll my child in the scouting programs and participate in related activities.

APPROVAL: YES_____ NO_____ INITIAL_____

CONSENT FOR EDUCATION FROM OUTSIDE SPEAKERS

I understand that Parkside brings in outside speakers to educate patients in their various areas of expertise. Speakers sign a confidentiality agreement upon entrance to the unit

APPROVAL: YES_____ NO_____ INITIAL_____

Signature of patient or legal guardian Date

Signature of witness by staff **Date**

Parkside
Psychiatric Hospital & Clinic

OKLAHOMA HEALTH CARE AUTHORITY
CONDITIONS OF TREATMENT
PARTICIPATION
INPATIENT PSYCHIATRIC PROGRAMS FOR CHILDREN

Patient Label

Programs that provide inpatient acute or residential psychiatric services to the children under contract with the Oklahoma Health Care Authority must provide a program of "Active Treatment", "Active Treatment" includes the participation of the patient's family or guardian in the following ways while the patient remains in the care of the treatment program.

1. Upon admission to an inpatient psychiatric program the patient's family or guardian will review the organization's written policy regarding patient's rights, behavior management of patients, patient grievance procedures, and access to the Office of Client Advocacy.

2. The child's family or guardian will communicate with treatment team members to provide available information necessary for the patient assessment and treatment. This information includes, but may not be limited to the patient's past and current physical, medical, developmental, social, emotional, academic and behavioral status.

3. The patient's family or guardian will communicate on a regular basis with treatment team members, and as indicated by team recommendations for the child's continued treatment needs. This will allow the child's family or guardian to participate in the planning of their child's treatment and .discharge needs.

4. The patient's family or guardian understands that the purpose of treatment within an acute or residential psychiatric program is to stabilize disabling symptoms that pose an immediate threat to the life of the child and or others. It is within the rights of the child to receive treatment in the least restrictive setting and return to their community as soon as he or she is able.

5. The patient's family must participate in family sessions on a regular basis. The family must participate in at least one family session per week for the patient receiving treatment in an acute or a residential psychiatric program. The family understands that the treatment team member responsible for coordinating their regular family sessions will document the family or guardian's efforts to attend and the record of their attendance.

I certify that I have read or that I have had these statements read to me. I understand the conditions of participation stated herein. The personnel of the admitting facility have provided me the opportunity to have questions concerning these conditions answered. My signature below indicates that I agree to participate in treatment as stated in these conditions and as they apply to the patient. I understand that my failure to meet these conditions through attendance and or participation could have an effect on the continued treatment of the patient and result in discharge from the present inpatient treatment.

MRN	Patient Name (Please print)
Date	Signature and Relationship to patient
Date	Signature of Witness

Parkside
Psychiatric Hospital & Clinic

BEHAVIORAL HEALTH SERVICES

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION AND RECEIVE DELIVERIES

Patient Label

Security Code _____

This consent and authorization regards: _____
(Patient Name)

Name of Legal Guardian _____ ☐ **Parent** ☐ **DHS** ☐ **OJA** ☐ **Other** _____

1. The patient's legal guardian defines who can have contact with the patient as listed below. No other individuals will be allowed contact or information about the patient. The list should be limited to people who will be directly involved in the patient's treatment while at Parkside.
2. This list may be changed at any time by written request by the legal guardian. Any release made prior to written revocation in reliance upon this authorization shall not be a breach of right of confidentiality.
3. This consent shall automatically expire at discharge if not revoked at an earlier date.
4. **The following individuals may be contacted by the staff of Tulsa Center for Adolescent Treatment to obtain information on the above named patient in order to develop the most effective treatment plan.**
5. The following individual may contact the staff at Tulsa Center for Adolescent Treatment to obtain information regarding the status of the above referenced patient.
6. The following individuals may contact by telephone or visit the above referenced patient.
7. I release Tulsa Center for Adolescent Treatment and its staff of responsibility for confidentiality as it relates to deliveries so that I may receive MAIL, FLOWERS, LEGAL DOCUMENTS, LEGAL SERVICES, AND PERSONAL ITEMS, while I am hospitalized. I understand it is necessary to release limited information in order to receive these services.
8. By initialing the boxes below and signing my name, I understand that I am consenting for those individuals to call the patient, visit the patient, be contacted regarding the patient referenced above, and to receive deliveries.

NAME	RELATIONSHIP	PHONE	STAFF MAY CONTACT	MAY CONTACT PATIENT	MAY CONTACT STAFF	MAY VISIT PATIENT	DATE REVOKED

Patient Signature **Date** **Witness Signature** **Date**

Parent or Legal Guardian **Date** **Witness Signature** **Date**

Parkside
Psychiatric Hospital & Clinic

STATEMENT OF LEGAL GUARDIANSHIP

Patient Label

+Must be completed for: Adults who have a Legal Guardian and ALL *Minors/Adolescents* receiving treatment.

I. Legal Guardian for Minors / Adolescents / Adults having a Legal Guardian.

Name of person having legal guardianship: _____

Relationship to patient: _____

Address: _____

Home phone: _____ **Work phone:** _____

Cell phone: _____ **Emergency phone no.** _____

Fax Number: _____

Name of person(s) having physical custody: (if different from above) _____

Relationship to patient: _____

Address: _____

Home phone: _____ **Work phone:** _____

Cell phone: _____ **Emergency phone no.** _____

Fax number: _____

Legal documentation of guardianship / custody present at intake: ☐ **YES** ☐ **NO**

☐ **Letters of Guardianship (Adults only)** ☐ **Order of Guardianship (All patients)**

☐ **Birth Certificate** ☐ **Divorce Decree (must have if birth parents are divorced)** ☐ ***Child Custody Documents***

☐ **Other: (Adoption papers, Etc.)** _____

If no what is the follow-up plan? _____

II. People Involved in Patient's Care / Treatment ***(If listed above indicate "SAME")***

Biological / Adoptive Parents:

Mothers Name: _____	**Fathers Name:** _____
Address: _____	**Address:** _____
Home phone: _____	**Home phone:** _____
Cell phone: _____	**Cell phone:** _____
Work phone: _____	**Work phone:** _____
Emergency phone: _____	**Emergency phone:** _____
Fax number _____	**Fax number:** _____

Parents: ☐ **Married** ☐ **Never Married** ☐ **Living as married** ☐ **Separated**
☐ **Divorced** ☐ **Widowed**

Parkside
Psychiatric Hospital & Clinic

STATEMENT OF LEGAL GUARDIANSHIP

Patient Label

II. People Involved in Patient's Care / Treatment ***(if listed above indicate "SAME")*** **Cont...**

DHS Caseworker: None ☐

Name: _____
County: _____
Work phone: _____
After hours contact: _____
Home phone: _____
Pager number: _____
Fax number: _____

Supervisor: _____
Name: _____
County: _____
Work phone: _____
After hours contact: _____
Home phone: _____
Pager number: _____
Fax number: _____

OJA / or Probation Officer: None ☐

Name: _____
County: _____
Work phone: _____
After hours contact: _____
Home phone: _____
Pager number: _____
Fax number: _____

Supervisor: _____
Name: _____
County: _____
Work phone: _____
After hours contact: _____
Home phone: _____
Pager number: _____
Fax number: _____

Foster Family: None ☐

Mothers Name: _____
Address: _____
Home phone: _____
Cell phone: _____
Work phone: _____
Emergency phone: _____
Fax number: _____

Fathers Name: _____
Address: _____
Home phone: _____
Cell phone: _____
Work phone: _____
Emergency phone:
Fax number: _____

I attest that this information is true and accurate to the best of my ability. I give consent to Parkside, Inc. to contact the individuals and agencies listed on this document in order to provide services and treatment.

_____ _____
Legal Guardian Signature **Date**

_____ _____
Staff Witness Signature **Date**

Parkside
Psychiatric Hospital & Clinic

CASE MANAGEMENT REFERRAL AND DISCLOSURE OF PERSONAL HEALTH INFORMATION FORM

(not used for DHS/OJA custody kids)

Patient Label

Hospital **Parkside Psychiatric Hospital & Clinic**

Address **1620 East 12th Street** City, State, Zip **Tulsa, OK 74120**

To disclose Personal health Information for _____, including diagnosis, psychological and physiological assessments and treatment and discharge planning to the following:

Case Management Agency _____

Address _____

City, State, Zip _____

Phone ( ) _____ Contact Person _____

Case managers help you and your families gain access to community services including mental health, medical care, food, clothing, housing, transportation, educational and vocational services that can make the transition home much easier. The entire community is viewed as a potential resource. The focus for the helping process is on your strengths, interests, abilities, knowledge and capabilities, not weaknesses or deficits. The relationship between you, your family and the case manager is characterized by collaboration and partnership. The child and family are viewed as directors of the helping process. Your hospital works with the Case Management Agency and other services to assure you and your child have all the essential services required at the time of discharge. Your case Manager continues this process by assisting your family in your community after discharge.

Patient Name _____ SS# _____

Address _____ MC# _____

City, State, Zip _____ Phone ( ) _____

Parent/Guardian Name _____ Secondary # ( ) _____

By signing below, I acknowledge and understand that:

This authorization is voluntary. I may revoke this authorization at any time by writing to _____ at the address above. If I do not revoke this authorization, it will be valid until (date) _____. Personal Health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the privacy rules of the U.S. Department of Health and Human Services.

☐ Please check this box and sign below, if you wish to refuse case management services at this time.

_____ Date: _____

Signature of Consumer (if 14 or over)

_____ Date: _____

Parent/Guardian

_____ Date: _____

Hospital Representative

One copy to Caregiver, file, and faxed to the chosen CM agency.

The CM Agency has assigned the following Case Manager _____

Phone# _____ to this case. The case Mgr. Will be contacting the hospital and the family to assist in coordination of needed Case Management services prior to discharge.

CM Agency faxes back to the Hospital to file.

Disclosure of Information for CM services – for Hospitals

Patient Label

Parkside
Psychiatric Hospital & Clinic

MEDICAL HISTORY

Date: _____

Patient's Name: _____
Parent's or Guardian's name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ _____Male _____ Female

Medical History –

Primary Cary Physician: Yes _____ No _____
Name of Primary Care Physician: _____ Dr's phone: _____
Date of last physical: _____

Do you have allergies to any type of:
Medications? _____ Yes _____ No
Foods? _____ Yes _____ No
Environmental? _____ Yes _____ No
If yes, list what they are allergic to and type of reaction: _____

List any medication that you are currently taking (including vitamins, over the counter and home remedies):
Name_____ dosage _____ when: _____ how long: _____ Dr. prescribing: _____

What has been your response to the above listed medications: _____

Are you taking your medication as prescribed by your doctor/s? Yes _____ No _____
If no, please explain: _____

General Health Information about the patient:

Have you ever had or have you now ..... Please check all that apply.

History of: ☐ **None**

☐ AIDS/HIV ☐ Cancer ☐ Gall bladder disease
☐ Diabetes ☐ Oral diabetic meds ☐ Take insulin
☐ Diabetes diet controlled (only) ☐ Tumor, growth or cysts ☐ Thyroid disease

Please explain: _____

Cardiac (heart): ☐ **No problems**

☐ High blood pressure / Hypertension ☐ Heart Attack ☐ Heart Disease
☐ Low blood pressure ☐ Palpitation / pounding heart ☐ Chest pain or pressure
☐ Hardening of arteries ☐ Anemia / blood disorders ☐ Abnormal EKG

Please explain _____

Liver & Kidneys: ☐ **No problems**

☐ Liver disease / problems ☐ Jaundice ☐ Hepatitis A
☐ Hepatitis B ☐ Hepatitis C ☐ Kidney stones
☐ Blood in urine

Please explain _____

Respiratory (breathing or lungs): ☐ **No problems**

☐ Asthma ☐ Allergies (seasonal) ☐ Shortness of breath
☐ Chronic cough ☐ Wheezing ☐ Bronchitis
☐ Pneumonia ☐ Emphysema ☐ Tuberculosis
☐ Use a C-Pap machine at night ☐ receive breathing treatments
☐ Smoker (packs per day _____, number of years you have smoked _____)

Please explain _____

Neurological: ☐ **No problems**

☐ Head injury ☐ Concussion ☐ Loss / difficulty with of memory
☐ Loss of consciousness ☐ Stroke ☐ Paralysis (include infantile)
☐ Migraine headaches ☐ Frequent headaches ☐ Fainting episodes
☐ Seizures ☐ Falling down ☐ Dizziness

Please explain _____

Sleep: ☐ **No problems**

☐ Trouble falling asleep ☐ Frequent waking ☐ Early waking
☐ Bad dreams / Nightmares ☐ Snoring ☐ Periods of apnea during sleep
☐ How many hours to you sleep per night do you get (on average) _____ ☐ Sleepwalking

What helps you fall asleep?

☐ Nothing ☐ Medication ☐ Food
☐ Alcohol ☐ Reading ☐ Watching TV
☐ Listen to music ☐ Other, please explain _____

If you take medication for sleep what do you take and how often: _____

Digestive / Elimination: ☐ **No problems**

☐ Stomach indigestion ☐ Stomach ulcers ☐ Nausea / vomiting
☐ Cold / mouth sores ☐ Food allergies ☐ Weight gain / loss
How much_____ Time period____

Urination problems: ☐ No problems

☐ Burning / painful ☐ Hesitancy ☐ Incontinence / leaking
☐ Stress incontinence ☐ Blood in urine ☐ Bed wetting since age 12
Please explain: _____

_____

Bowel Problems: ☐ No problems

☐ Constipation ☐ Loose stools ☐ Diarrhea
☐ Blood in stool ☐ Use aids for elimination needs (laxatives)
Please explain: _____

_____

Behavior / Activities: ☐ **No problems**

☐ Hyperactive behavior ☐ ADD/ADHA ☐ Short attention span
☐ Easily angered ☐ physically abusive to others ☐ No energy to do things
☐ Verbally abusive to others ☐ Bath /shower routinely
Please explain: _____

Skin & Skeletal: ☐ **No problems**

☐ Arthritis ☐ Bone / Joint deformity ☐ Recurrent back pain
☐ Joint pain ☐ Difficulty walking ☐ Use assistive device
☐ Tattoos (where? _____) ☐ Bruises (where? _____) ☐ Birthmarks
☐ Piercings (where? _____)
Please explain:

_____

_____

Senses – do you have difficulty with: ☐ **No problems**

☐ Speech ☐ Vision ☐ Glasses or contacts
☐ Glasses or contacts ☐ Loose or missing teeth ☐ Dentures or Partials
With patient? _____ y / n With patient? _____ y / n
☐ Smells ☐ Allergies ☐ Taste
☐ Hard of hearing ☐ Hearing aids
Please explain _____

_____

Reproductive

Are you sexually active? _____ yes _____no
Do you use protection? Condoms ____ Birth Control Pills ___ Other contraceptives (type) _____
Females:
Age you started your periods _____ Date of your last period _____
Date of last pap smear _____ Breast lumps / tenderness _____
Nipple discharge _____ ☐ Pregnant (weeks _____)
☐ Abortions (how many _____) ☐ Miscarriages (how many _____)
☐ Menopause (onset at what age _____)
☐ History of STD (sexually transmitted disease) (what_____)

Males:

☐ Penile discharge ☐ Date of last testicular exam _____

Please explain _____

_____

Pain Screening

Are you in pain now? Yes _____ No _____

Where is the pain located? _____

_____

Rate pain level (1 – 10) _____ (1 = lowest: 10 = highest)

Self Care

☐ Have your tried to injure yourself on purpose (cutting, burning, suicide attempt). Please explain (when & how)

_____

_____

Substances

Use of:	Yes	How much	Last used
Liquor (alcohol)	____	_____	_____
Beer	____	_____	_____
Marijuana	____	_____	_____
Cocaine	____	_____	_____
Pain medications	____	_____	_____
Anxiety medications	____	_____	_____

Other substances _____

_____

Is there any other information that you need to let us know about that was not covered in any of the above questions? Please explain _____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Person Completing Form Date

_____

Relationship to Patient

Parkside
Psychiatric Hospital & Clinic

Parkside Inc.
CONSENT FOR DRUG THERAPY

Label

I understand that medication cannot be administered to me (or my minor) until I have given consent, except in an emergency.

Dr._____ has recommended that these medications may be needed to treat my chemical imbalance, mental condition or illness, including the likelihood of my condition improving or not improving without the medicine.

Mood Stabilizer: _____

Antidepressant: _____

Antipsychotic: _____

Antianxiety: _____

Stimulant: _____

Other: _____

I have been given specific information concerning benefits and possible risks of these medications, including potential side effects. I will make known to the physician, any side effects I encounter, for proper treatment assessment.

- ❑ Drug information sheet(s) provided in person or faxed to appropriate parent/caseworker/guardian.

I have been informed of available alternative therapies to this treatment and I understand that **unless ordered by the court**, I may stop the medication at any time and continue to obtain other treatment.

CHECK ONE

- ❑ I give my consent to receive this medication. (Patient)
- ❑ I give my consent for my child to receive medication, and that I have had time to discuss and understand this information.(Parent/Guardian)
- ❑ I **do not** give consent for medication.

SIGNATURE: _____ Date: _____
(Patient over age 18, Custodial parent, Legal guardian or Emancipated Minor)

This person is:

- ❑ Capable of giving informed consent.
- ❑ Willing to take medication, but unable to give informed consent.
- ❑ Court Ordered to be treated with medication.

SIGNATURE: _____ Date: _____
(Physician)

Phone Consent:
Name of person with whom discussed: _____ Date: _____
Relationship to above patient: _____ Date: _____
RN/LPN Witness: _____ Date: _____
Staff WITNESS: _____ Date: _____

Parkside
Psychiatric Hospital & Clinic

Authorization for Use and Disclosure of Protected Health Information

For exchange of information between Parkside and ONE facility or person

Patient Label

Patient Name:	Record #:
Address:	Birth Date:
Phone no:	Social Security No:

Name: **Parkside Hospital**	Name:	***Check as many as apply***	
Attn: **Medical Records**	Address:	Send to ☐	Mail ☐
Address: **1620 East 12th St.**		Receive from ☐	Fax ☐
Tulsa, OK. 74120	Phone: Fax:		Verbal ☐

MINIMUM NECESSARY INFORMATION TO BE RELEASED/SHARED for services from: _____ to _____

☐ Discharge Summary ☐ Psych Evaluation ☐ Treatment Plan(s) ☐ Psychosocial exam ☐ Progress Notes ☐ Medication sheets
☐ Other specify):__ _____

PURPOSE (CHECK): ☐ Treatment/consult ☐ Patient use ☐ Verify treatment ☐ Other: _____

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE:

Information in your medical record that you have or may have a communicable or noncommunicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court, by the Department of Health or by law.

I UNDERSTAND THAT:

- If my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I agree to its release: _____ ***initials***
- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that if my records contain alcohol and /or drug treatment information and I am legally considered a minor, I am the responsible individual that must authorize this disclosure (per 63 Okla.Stat. 2602).
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in 6 months or as follows: _____.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I have been provided a copy of this form.
- I may inspect or copy the protected health information to be used or disclosed.
- **Payment for records is required in advance of receipt of records.**

I authorize the above-named entity to use and disclose the confidential and protected health information specified above:

Signature: _____ Date/time: _____ ____:____

Signature of person signing form if not patient: _____ Authority: _____

Identity verified via: ☐ photo ID ☐ matching signature ☐ other: _____ Staff signature: _____

Parkside
Psychiatric Hospital & Clinic

Parkside Inc.
CONSENT FOR DRUG THERAPY
(Over the Counter Medications)

Label

I understand that medication cannot be administered to me (or my minor) until I have given consent, except in an emergency.

Dr._____ has recommended that these medications may be needed to treat my chemical imbalance, mental condition or illness, including the likelihood of my condition improving or not improving without the medicine.

Mood Stabilizer: _____

Antidepressant: _____

Antipsychotic: _____

Antianxiety: _____

Stimulant: _____

Other: **Cepacol – Nex – MOM-Maalox-Tylenol-Benadryl-Chapstick-Imodium-Sudafed-Melatonin**

I have been given specific information concerning benefits and possible risks of these medications, including potential side effects. I will make known to the physician, any side effects I encounter, for proper treatment assessment.

- ❑ Drug information sheet(s) provided in person or faxed to appropriate parent/caseworker/guardian.

I have been informed of available alternative therapies to this treatment and I understand that **unless ordered by the court**, I may stop the medication at any time and continue to obtain other treatment.

CHECK ONE

- ❑ I give my consent to receive this medication. (Patient)
- ❑ I give my consent for my child to receive medication, and that I have had time to discuss and understand this information.(Parent/Guardian)
- ❑ I **do not** give consent for medication.

SIGNATURE: _____ Date: _____
(Patient over age 18, Custodial parent, Legal guardian or Emancipated Minor)

This person is:

- ❑ Capable of giving informed consent.
- ❑ Willing to take medication, but unable to give informed consent.
- ❑ Court Ordered to be treated with medication.

SIGNATURE: _____ Date: _____
(Physician)

Phone Consent:
Name of person with whom discussed: _____ Date: _____
Relationship to above patient: _____ Date: _____
RN/LPN Witness: _____ Date: _____
Staff WITNESS: _____ Date: _____

Parkside
Psychiatric Hospital & Clinic

Parkside Inc.
CONSENT FOR DRUG THERAPY
(Behavior Emergency Only)

Label

I understand that medication cannot be administered to me (or my minor) until I have given consent, except in an emergency.

Dr._____ has recommended that these medications may be needed to treat my chemical imbalance, mental condition or illness, including the likelihood of my condition improving or not improving without the medicine.

Mood Stabilizer: _____

Antidepressant: _____

Antipsychotic: **Geodon – Thorazine – Zydis**

Antianxiety: _____

Stimulant: _____

Other: **Benadryl – Vistaril**

I have been given specific information concerning benefits and possible risks of these medications, including potential side effects. I will make known to the physician, any side effects I encounter, for proper treatment assessment.

- ☐ Drug information sheet(s) provided in person or faxed to appropriate parent/caseworker/guardian.

I have been informed of available alternative therapies to this treatment and I understand that **unless ordered by the court**, I may stop the medication at any time and continue to obtain other treatment.

CHECK ONE

- ☐ I give my consent to receive this medication. (Patient)
- ☐ I give my consent for my child to receive medication, and that I have had time to discuss and understand this information.(Parent/Guardian)
- ☐ I **do not** give consent for medication.

SIGNATURE: _____ Date: _____
(Patient over age 18, Custodial parent, Legal guardian or Emancipated Minor)

This person is:

- ☐ Capable of giving informed consent.
- ☐ Willing to take medication, but unable to give informed consent.
- ☐ Court Ordered to be treated with medication.

SIGNATURE: _____ Date: _____
(Physician)

Phone Consent:
Name of person with whom discussed: _____ Date: _____
Relationship to above patient: _____ Date: _____
RN/LPN Witness: _____ Date: _____
Staff WITNESS: _____ Date: _____

Parkside
Psychiatric Hospital & Clinic

VERIFICATION OF MEDICATION(S)

Patient Label

As the DHS Caseworker assigned to patient, _____, I understand I am unable to give consent for any medications that may be ordered for this patient. However, I can verify he/she is taking the following medication(s).

Name of medication(s)	Dosage	Frequency

Signature: _____ **Date:** _____
DHS Caseworker

Witness Signature: _____ **Date:** _____
RN / LPN

Parkside
Psychiatric Hospital & Clinic

NOTICE OF PRIVACY PRACTICES

Patient Label

Patient Name_____ Patient ID _____

JOINT NOTICE OF PRIVACY PRACTICES

RECEIPT ACKNOWLEDGEMENT

A complete description of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES.

I have received a copy of Parkside's Joint Notice of Privacy Practices.

Patient Signature_____ Date _____

Witness Signature_____ Date _____

TULSA PUBLIC SCHOOLS – PA9

Special Facilities – ENTRY FORM

STUDENT ID #: **SITE #:**	**ENTRY DATE:** **ENTRY CODE:**	**PERSON COMPLETING FORM:**
Student's Last Name:	Legal First Name:	Legal Middle Name:
Date of Birth:	Social Security Number:	Student's Current Age: Student's Current Grade:
Ethnicity: Is the student Hispanic or Latino culture or origin? Yes or No?		
Race: (Please highlight (found on the tool bar) ALL that apply) White Black or African American Asian American Indian or Alaskan Native Native Hawaiian or other Pacific Islander		Gender: (Please highlight One) Male Female
Student lives with: (Highlight One) Both Parents Mother Father Court Guardian/DHS Other		**STUDENT BIRTHPLACE:**
Does the student receive Medicaid Benefits? Yes or No?		If Yes, list Medicaid #:
Name and Address of Last School Attended: Name: Street Address: City: State: Zip:		
Name of Legal Parent/Guardian #1	**Home Address: Street**	**Home Address: City, State, Zip**
Home Phone:	Cell Phone:	Work Phone:
Name of Legal Parent/Guardian #2	**Home Address: Street**	**Home Address: City, State, Zip**
Home Phone:	Cell Phone:	Work Phone:
Doctor's Name:		Phone Number:

SPECIAL EDUCATION CATEGORY – PLEASE CHECK ALL THAT APPLY

☐ A ☐ D ☐ DB ☐ DD ☐ ED ☐ HB ☐ HI
☐ ID ☐ LD ☐ MD ☐ OHI ☐ OI ☐ TBI ☐ VI

RELATED SERVICES:

☐ OT ☐ PT ☐ SI

PROGAM DESIGN:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 6 ☐ 8 ☐ 9 ☐ 10
☐ A1 ☐ A2 ☐ A3 ☐ B1 ☐ B2 ☐ B3 ☐ B4 ☐ B5

OKLAHOMA
STATE DEPARTMENT of EDUCATION
JANET BARRESI

Janet Barresi
State Superintendent of Public Instruction
Oklahoma State Department of Education

2011-2012 Home Language Survey for Pre-K-12 School Districts

Name of Student: _____
Last Name First Name Middle Name

Student ID #: _____ Gender: ☐ Male ☐ Female

School Site: _____ Grade: _____

Date of Birth: _____ Place of Birth (City/State/Country): _____

Is the student of Hispanic or Latino culture or origin? ☐ Yes ☐ No

Select one or more of the following races: ☐ African American/Black ☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian/White

Parent's/Guardian's Name: _____

Parent's/Guardian's Address: _____
Street City Zip Code

Parent's/Guardian's Telephone Number: (_____) _____ Cell Phone: _____

1. Is a language **other than English** used in your home? ☐ Yes ☐ No

   If NO, go to numbers 6 and 7. If YES, what is that language? _____

2. Is that language spoken in the home ☐ More Often than **English**? ☐ Less Often than **English**?

3. What language is spoken by adults in the home? _____

4. What was the first (1st) language your child learned to speak? _____

5. What was the date (month and year) your child first enrolled in a school in the United States? _____

6. Parent/Guardian Signature: _____

7. Date: _____

FOR SCHOOL USE ONLY

THIS FORM MUST BE COMPLETED EVERY YEAR WITH CURRENT TEST DATA FOR STATE ACCREDITATION.

☐ If a language other than English is spoken MORE OFTEN (see question #2), the student automatically qualifies as bilingual on application for accreditation.

OR

If a language is spoken LESS OFTEN, student qualifies as bilingual on application for accreditation if he or she meets ONE OF THE FOLLOWING:

☐ 1. Scores 35% or below on norm-referenced test (NRT) on the composite **reading** score.
☐ 2. Scores limited knowledge or unsatisfactory on **Reading** Oklahoma Core Curriculum Tests (OCCTs).
☐ 3. Designated Limited English Proficient on an Oklahoma English language proficiency assessment: WIDA ACCESS for English language learners (ELLs) Test, WIDA Placement Test (including K W-APT, W-APT, and Kindergarten MODEL), or the Oklahoma Pre-K Language Screening Tool.

Documentation of a test result for students who marked LESS OFTEN:

1. NRT Test Date: _____ Name of the NRT: _____ Reading Total Composite Score: _____

2. Reading OCCT Date: _____ Score on Reading OCCT: ☐ Limited Knowledge ☐ Unsatisfactory ☐ Satisfactory ☐ Advanced

3. ACCESS for ELLs Test Date: _____ Score on ACCESS for ELLs: 1 _____ 2 _____
   WIDA Placement Test (K W-APT, W-APT, or Kindergarten MODEL) Date: _____ Score on K W-APT, W-APT, or MODEL: 1 _____ 2 _____
   Oklahoma Pre-K Language Screening Tool Date: _____ Score on Pre-K Language Screening Tool: _____

1 Composite Score 2 Literacy Score

REVISED 7-27-2011

Site: _____ **School Year:** _____

Initial Enrollment Prior Participation Form

Student Information

ONLY FOR GRADE LEVEL: Pre-K, KG, 1ST

The following information should be completed by the parent or guardian of the student. This information is collected on a student's initial enrollment into an Oklahoma school district. Please print legibly.

Student Legal Name: _____ _____ _____
LAST FIRST MIDDLE

Student ID #: _____

Student Date of Birth: _____ _____ _____
Month Day Year

Student Gender - Please check one: Male ☐ Female ☐

Student Grade Level: Pre-K ☐ KG ☐ 1st ☐

Did the student participate in any of the following programs? Please indicate by checking YES or NO for each statement.

PROGRAM	YES	NO
A childcare program that is licensed pursuant to the tiered licensing system established by the Department of Human Services (a DHS licensed childcare program)		
The Sooner Start program operated by the State Department of Education		
The Oklahoma Parents as Teachers (OPAT) program operated by the State Department of Education		
The Children First program operated by the State Department of Health		
Any child abuse prevention program operated by the State Department of Health		
Any federally funded Head Start program		

INDEPENDENT SCHOOL DISTRICT #1

OF TULSA COUNTY, OKLAHOMA

PARENTAL REQUEST/RECORDS RELEASE AUTHORIZATION

FOR STUDENT RECORDS

The undersigned hereby authorizes: _____

Name of School & Address

to release copies of the following official records: **All school records, immunizations, cumulative, withdrawal grades, psychological evaluations and confidential files:** for

_____

FULL Legal Name of Student Birth date Grade

To: Tulsa Public Schools
ATTN: George C Howard
TCAT-621
3027 S New Haven
Tulsa, Ok 74114

Reason for Request: Enrollment and Evaluation

_____

Parent/Legal Guardian Date

_____

I hereby authorize and give my permission to Tulsa Public Schools to release school records after discharge for purposes of facilitating appropriate educational programming and help in evaluation and recommendation for present and future educational programming to:

_____

Name of School, Address, City, State, Zip Code

RE: School enrollment or educational planning for re-entry by telephone or personal conference.

_____

Parent/Legal Guardian Date

_____

Home Address, City, State, Zip Code

_____

Witness Signature