Parkside
Psychiatric Hospital & Clinic

ACCESS Tracking Sheet

Checklist	Time Completed	Patient's Mood Calm=C Agitated=A	Staff's initials	Notes:
Patient Arrival Time				
Belongings secured – wanded, items bagged				
Stroke Assessment Completed				
Consents signed – *paperwork completed*				
Medical Review – *VS, med rec, needs current conditions*				
Dr Called – *list name of doc*_____				
Nursing Assessment – *as complete as possible*				
Body Search – *patient now in gowns*				
Sent out for medical Clearance *state reason*				
Released to Home – *with safety plan*				
Ready for the unit				
Patient escorted to the unit				

Nursing Assessment Task List

- ☐ Med/Rec
- ☐ Fall Assessment
- ☐ Review of Systems
- ☐ Aims
- ☐ Sexuality
- ☐ Habits
- ☐ Education (body check)
- ☐ Allergies
- ☐ Nutrition Screening
- ☐ Youth Addendum
- ☐ CSSR-S
- ☐ Initial Orders obtained
- ☐ Initial Orders put in
- ☐ Consents for medications signed
- ☐ Home meds

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

PATIENT INFORMATION

Please provide us with the current information below so we can keep your file accurate and up to date. We request that you please print the information legibly. Thank you for your cooperation.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI:_____

Date of Birth: _____ Age: _____ Social Security Number _____

Sex M or F Other_____ Maiden Name (if applicable) _____

Current Mailing Address: _____

City: _____ State: _____ Zip _____ Email:_____

Cell Phone: _____ Home Phone: _____

Employer: _____ Work Phone: _____

MARITAL STATUS (circle one): Married Single Divorced Widowed Legally Separated Life Partner

Race: __White/Caucasian ___African American___ Native American___ Alaskan Native ___Asian ___Hispanic/ Latino __Non-Hispanic Latino___ Pacific Islander ___Other, Not Listed

Ethnicity: __Mexican __ Puerto Rico___ Cuban ___Other Hispanic ___Not Hispanic __African American ___Native American ___White/Caucasian ___African ___European___ Other Not Listed ___Unknown

PARENT/LEGAL GUARDIAN INFORMATION

Last Name: _____ First Name: _____ MI:_____

Date of Birth: _____ Relationship to Client: _____ Social Security Number _____

Current Mailing Address: _____ City_____

State_____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____

Employer: _____ Work Phone: _____

EMERGENCY CONTACT

Last Name: _____First Name: _____

Relationship to Client: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

If there is another biological, adoptive, or legal parent/guardian, please provide their information with a note about their legal rights.

Signature_____ Date: _____

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FINANCIAL INFORMATION

Patient Name: _____ DOB: _____ SSN:_____

Medicaid

Policy #:_____

Annual Household Income: _____

Total Household Size: _____

Medicare

Policy#: _____

Name on Card: _____

Primary Insurance Information: *To verify benefits and file claims, all information must be provided below.*

Insurance Company: _____ Phone: _____

Subscriber Last Name: _____ First Name: _____ MI: _____
Subscriber SSN: _____ DOB: _____ Relationship to Client: _____

Policy#: _____ Group #: _____ Group Name: _____

Employer Name: _____ Employer Phone #: _____

Secondary Information (if applicable):

Insurance Company: _____Phone: _____

Subscribed Last Name: _____ First Name: _____

Subscriber's SSN: _____DOB: _____ Relationship to Client:_____

Policy #: _____ Group #_____ Group Name: _____

Employer Name: _____ Employer Phone #: _____

Other Insurance (if applicable):

Insurance Company: _____ Phone: _____

Subscriber Last Name: _____ First Name: _____ MI: _____

Subscriber SSN: _____ DOB: _____ Relationship to Client:_____

Policy#: _____ Group #: _____ Group Name: _____

Employer Name: _____ Employer Phone #:_____

___Self Pay. No Insurance Coverage: Payment due in full at time of service. Self-pay discount applies.

Signature: _____ Date: _____

Parkside
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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 Parkside 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 Parkside 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 Parkside 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

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

I am informed that this hospital is under camera surveillance inside and outside. This includes all treatment areas but not bedrooms and/or bathrooms.

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_____

OPPORTUNITY TO EXECUTE AN ADVANCE DIRECTIVE

I have been educated about Advance Directives and I have been informed of my right to formulate an Advance Directive. I have been offered assistance to write an advance directive. I understand that I do not have to have an Advance Directive to receive treatment at this hospital.

APPROVAL: YES_____ NO_____ INITIAL_____

RESTRAINT AND SECLUSION CONSENT AND EDUCATION

I have had education on restraint and seclusion used here at Parkside. I understand that this is a last resort to prevent harm to the patient or others. Restraint and seclusion techniques are not used for discipline or convenience. This intervention can involve holding a patient or placing them in a locked room. At times, emergency psychiatric medication may be required. During a time of restraint and/or seclusion, the patient is monitored closely, and this intervention will be discontinued as soon as it is safely possible.

APPROVAL: YES_____ NO_____ INITIAL_____

NOTICE OF PRIVACY PRACTICES

I have read the Parkside Privacy Practices. I have been given a copy if I requested one. My Rights and Responsibilities have been given to me.

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 patient Date

Signature of witness by staff **Date**

Parkside Psychiatric Hospital & Clinic

INFORMED CONSENT FOR TREATMENT

Patient Label

_____INFORMED CONSENT FOR TELEHEALTH:

Initial

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of providing patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: patient medical records, and live two-way audio and video communication. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Records of the telehealth encounter will be entered into Parkside's electronic medical record keeping system and are available from Parkside's Health Information Management department in accord with regular medical records policy.

Expected Benefits: improved access to care, decreased need for travel, more efficient evaluation, obtaining the expertise of a specialist.

Possible Risks: telehealth encounter failure due to equipment or connection failure, in very rare instances, security protocols could fail or partially fail causing a possible breach of personal health information.

Upon providing your electronic signature, you acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I understand that portions of my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained.

_____PERSONAL BELONGINGS & RELEASE OF RESPONSIBILITY:

Initial

1. Parkside, Inc. is hereby released from any responsibility for personal property I do not provide 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:

Initial

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. The inpatient treatment team will review any restrictions daily. 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 others, or myself I may be detained for up to five (5) business days excluding weekends and holidays 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:

initial

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.

Parkside
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INFORMED CONSENT FOR TREATMENT

Patient Label

_____ REVIEWED:

Initial

I have received copies of the following: Patient and Client Rights, Patient and Client Responsibilities, Medicare Patient and Client Appeal Process, Grievance process, Notice of Privacy Practices 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:

Initial

I hereby certify that I have read the contents of Informed Consent for Treatment 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_____Date_____

Signature of patient, 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: _____

Parkside
Psychiatric Hospital & Clinic

NOTICE OF GRIEVANCE RIGHTS

The Office of Client Advocacy (OCA) administers a fair, simple, and timely grievance system. Grievances can be filed by, or on behalf of, minors. Policies describing the grievance system are found in OAC 340:2-3-45 through 49.
At Parkside patients, families, guardians, and persons of the patient's choice (representative or advocate) will be given the opportunity to express any complaints, recommendations, and grievances. Presentation of the aforementioned will not serve to compromise the patient's current and/or future treatment or access to care nor will the patient be subjected to coercion, discrimination, reprisal, or unreasonable interruption of care.
You have a right to file a grievance, to receive a written response to your grievance, and to appeal if you are not satisfied with the response. You have the right to report allegations of abuse, neglect, and mistreatment. If any person attempts to deny you these rights or causes a problem for you when filing a grievance, contact your local grievance coordinator. If the local grievance coordinator is not helpful, you can call OCA at 405-522-2720 or 1-800-522-8014.

Who may file a grievance: Any patient at Parkside may file a grievance. Grievances may also be filed by anyone interested in a patient's welfare.

What complaints are considered: You may submit a grievance about any policy, rule, decision, behavior, or action by a Parkside employee or other persons authorized to provide care.

How to file a grievance: You have 15 business days from the date of your problem to file a grievance. To file a grievance, complete the **Grievance Form** which can be obtained from any Parkside staff member. However, an official grievance form is not required. A grievance can be written on a piece of paper. You may request help from any Parkside staff or from the local grievance coordinator filling out and filing the grievance. Submit the completed form to the local grievance coordinator. You may also give the completed form to any Parkside staff. They will get it to the local grievance coordinator.

What happens next: You will receive a written response approximately 10 business days after submitting your grievance. Your local grievance coordinator will contact you to discuss your grievance.

Tyler Doane — Local grievance coordinator
918-586-4233 — Phone number

Signatures
This notice was explained to:

_____ On _____
Patient signature — Date

_____ _____
Parent or legal guardian signature — Date

_____ _____
Staff Witness — Date

AUTHORIZATION TO DISCLOSE TO HEALTH INFORMATION NETWORK

Parkside participates in the MyHealth Health Information Exchange (HIE). This network allows other providers to access the information we have shared to better help them with your treatment. The information that Parkside shares includes:

- Demographic information (Name, address, phone number, insurance information)
- Dates of service
- Vital signs

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 1 year 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.

☐ **OPT IN**: I authorize Parkside to use and disclose to MyHealth Access Network the confidential and protected health information including DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS

☐ **OPT OUT**: I do **NOT** authorize Parkside to use and disclose to MyHealth Access Network. I am choosing to opt-out.

Patient Signature: _____Date/time: _____

Patient Print Name: _____

Parent/Guardian Signature: _____Date/time: _____

Parent/Guardian Print Name: _____

Relationship to patient: _____

Staff Witness Signature: _____Date/time: _____

Staff Witness Print Name: _____

Form W 603 adopted 5/2024