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

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

Restraint and Seclusion

PATIENT NAME: _____ Patient ID number: _____

Restraints are utilized only for patient protection and safety, not for discipline or convenience. Restraint Seclusion can involve holding a patient and/or placing them in a locked room. At times emergency psychiatric medications are required. This is also considered a restraint. For adult patients over 21 mechanical restraints may be indicated when other least restrictive methods fail.

Every effort will be made to use the least restrictive method of protection as well as preserving the patient's rights, dignity, and well-being as well as those of other patients and staff.

The nursing staff will monitor all aspects of restraint seclusion to maintain patient safety. Restraints will be removed as soon as possible while maintaining a safe environment.

I acknowledge receiving education about the use of restraint and /or seclusion:

_____ _____

Patient Signature Date/Time

_____ _____

Parent/ Legal Guardian Date/Time

_____ _____

Staff name/Signature Date/Time

Parkside

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

Parkside
Psychiatric Hospital & Clinic

CONSENT FOR TREATMENT
ANIMAL BASED / ENHANCED THERAPY

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

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

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

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

_____ _____
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 ☐	**Supervisor:**
Name:	**Name:**
County:	**County:**
Work phone:	**Work phone:**
After hours contact:	**After hours contact:**
Home phone:	**Home phone:**
Pager number:	**Pager number:**
Fax number:	**Fax number:**
Email Address	**Email Address**
OJA / or Probation Officer: None ☐	**Supervisor:**
Name:	**Name:**
County:	**County:**
Work phone:	**Work phone:**
After hours contact:	**After hours contact:**
Home phone:	**Home phone:**
Pager number:	**Pager number:**
Fax number:	**Fax number:**
Email Address	**Email Address**
Foster Family: None ☐	
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:**

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)

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 HEALTH QUESTIONNAIRE-9 (PHQ-9)

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle the number 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 fidgety 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 in some way	0	1	2	3

Parkside

Name of Patient: _____ **Date:** _____

Parent Questionnaire for New Admits

What are your primary concerns for your child?

_____

_____

_____

Has your child displayed significant behavioral changes in the last year? Explain

_____

_____

_____

Do you have any concerns for when your child returns home?

_____

_____

_____

Indicate areas and level of Concern, then provide details in area below

Indicate Concern Level by marking N = none, L = low, M = medium, H = high,

___Often fails to finish things he or she starts
___Shifts excessively from one activity to another
___Has difficulty waiting his/her turn
___Impulsive or acts without thinking
___Physically violent toward property
(vandalism, punching holes in walls)
___Physically abusive to self
(cutting, punching self, banging head to wall)
___Stealing, shoplifting, breaking and Entering
___Drug Abuse type and frequency _____
___Alcohol Abuse type and frequency _____

___Easily distracted
___Frequently is disruptive in class
___Has difficulty sitting still
___Has difficulty concentrating
___Abusive to animals
___Runaway
___Fire setting
___Lying
___Chronic violation of parental limits

_____

_____

_____

___Concern that people are out to get him/her
___Severe mood changes (very sad to very happy)
___Inappropriate expression of feelings (laughing at something sad)
___Strange thoughts or ideas (explain) _____
___Hallucinations (hearing or seeing things) describe _____
___Inappropriate sexual behavior (explain)_____

___Confused or seems to be in a fog
___Often appears sad

_____

_____

_____

___Feels no one loves him/her
___Clings to adults or too dependent
___Complains of loneliness/isolates
___Overly concerned with future events
___Very self-conscious or easily embarrassed
___Often appears tense and unable to relax
___Refusal to attend school
___Can't get his/her mind off certain things
___Nervous mannerisms (nail biting, thumb sucking, rocking)
___Acts too young for his/her age
___Gets teased/bullied
___Dramatic relationship with peers
___Feelings of inadequacy
___Avoidance of being left alone
___Fears he/she may do something bad
___Excessive need for reassurance
___Fears she/he has to be perfect
___Ritualistic behaviors
___Panic Attacks (feelings of intense fear/discomfort w/ increased heart rate, shortness of breath
___Obsessions or compulsions (unwanted/intrusive ideas, images or impulses that cause distress, high focus on germs, safety, order/consistency, systematic or ritualistic behaviors)
___Frequent physical complaints (headache, stomach ache, nausea)
___Unrealistic fears, explain _____

___Day dreams or gets lost in his/her thoughts
___Pessimistic/negative outlook toward future
___Suicidal thoughts or verbalization/texting of intentions
___Concerns about sexual identify
___Recurrent thoughts about death or preoccupation with death
___Low energy level/over tired
___Social withdraw/isolation
___Sexually promiscuous
___Eating problems

___Poor relationship with parents'
___Hangs with others that get in trouble
___Has difficulty making or keeping friends
___Does not associate with people of his or her own age
___Avoids unfamiliar social situation
___Tics (recurrent motor movements or vocalizations)
___Has difficulty participating in organized activities (sports)
___Sibling rivalry
___Mean to others
___Argues a lot, bragging, boasting
___Is easily led by others
___Avoids competitive situations
___Impaired sleep (too much, too little)

Additional Important Information for Doctor/Therapist

Person Completing Form & Relationship: _____

Parkside Inc.
CONSENT FOR DRUG THERAPY

Label

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

Mood Stabilizer (Specify) _____

Antidepressant (Specify) _____

Antipsychotic (Specify) _____

Antianxiety (Specify) _____

Stimulant (Specify) _____

Other (Specify) _____

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.

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.

☐ **I give my consent to receive this medication. (Patient)**

☐ **I give my consent for my child to receive medication; I have had the opportunity to discuss and understand this information.**

☐ **I DO NOT GIVE MY CONSENT.**

Name of person with whom discussed _____
(Print Name)

Relationship to above patient: _____

SIGNATURE: _____ Date: _____
Patient/ (Custodial parent /Legal guardian)

RN/LPN Witness: _____ Date: _____

Staff Witness _____ Date: _____

☐ **I have completed the Client/Caregiver Education Form in AVATAR**

Parkside Inc.
Over the Counter Medications

Label

Dr._____ has recommended that these medications may be needed to treat my/ my child's medical condition or illness.

Over the counter medications:

Abreva (Docosanol cream), acetaminophen, Acne treatment pads, Albuterol inhaler, Aleve (Naproxen), Bactroban (mupirocin), Benadryl (diphenhydramine), Benzoyl Peroxide gel for acne, Breathrite Strip, Calamine lotion, Calcium supplement, Cepacol throat lozenge, Cerumenex, Cetaphil lotion/body wash, Chloraseptic, Claritin (loratadine), Colace (docusate sodium), Debrox (carbamide peroxide), Delsym, Epsom Salts, Fish oil, Flonase, Guaifenesin, Hydrocerin cream, Hydrocortisone cream, Hydropha cream, Ibuprofen, Imodium, Kwell, Lip balm, Maalox, Melatonin, Midol, Milk of magnesium (MOM), Miralax, Mucinex, Multivitamin, Nicotine patch, Nix, Orajel, Phenylephrine (PE), Prevacid (lansoprazole), Prilosec (omeprazole), Protonix (pantoprazole), RID, Rewetting eye drops, Saline Drops, Silvadene , Singulair, Tinactin, Triple Antibiotic Ointment, Tucks, Tums, Ventolin, Vitamin E cream, Vitamin with Iron, Zantac (Ranitidine), zyrtec (centirzine)

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.

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.

☐ **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 MY CONSENT.**

Name of person with whom discussed _____
(Print Name)

Relationship to above patient _____

SIGNATURE _____ Date: _____
Patient/ (Custodial parent /Legal guardian)

RN/LPN Witness _____ Date: _____

Staff Witness _____ Date: _____

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

Label

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

Mood Stabilizer (Specify): _____

Antidepressant (Specify): _____

Antipsychotic (Specify): ziprasidone – haloperidol – risperidone chlorpromazine- – olanzapine

Antianxiety (Specify): lorazepam

Stimulant (Specify): _____

Other (Specify): diphenhydramine hcl – hydroxyzine - benztropine mesylate

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 encountered, for proper treatment assessment.

☐ **I give my consent to receive this medication. (Patient)**

☐ **I give my consent for my child to receive medication, I have had the opportunity to discuss and understand this information.**

☐ **I DO NOT GIVE MY CONSENT.**

Name of person with whom discussed _____
(Print Name)

Relationship to above patient _____

SIGNATURE: _____ Date: _____
Patient/ (Custodial parent /Legal guardian)

RN/LPN Witness _____ Date: _____

Staff Witness _____ Date: _____

Parkside

NOTICE OF PRIVACY PRACTICES

PATIENT LABEL

Patient Name_____ Patient ID _____

NOTICE OF PRIVACY PRACTICES

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

PATIENT RIGHTS AND RESPONSIBLITIES

A description of your rights and responsibilities as a patient at Parkside are provided at admission.

MEDICAL TREATMENT RIGHTS UNDER OKLAHOMA LAW

A description of your rights as required by section 3080.5(B) of Title 63 of Oklahoma Statutes.

RECEIPT ACKNOWLEDGEMENT

I have received a copy of Parkside's Notice of Privacy Practices, and Patients' Rights and Responsibilities.

Patient Signature_____ Date _____

Parent / Legal Guardian Signature_____ Date _____

Witness Signature_____ Date _____

TULSA PUBLIC SCHOOLS

Dear Parents,

Thank you for allowing us to work with your child in the classroom. While your child was in attendance with us he/she has been marked present for school and has been given grades for work completed in the four core subjects: English/Reading, Math, Science, and Social Studies. These grades are shared with the home school **once requested** and may be averaged into your child's grades. Student records can be requested at the following website: https://tulsaok.scriborder.com/ or by visiting the Tulsa Public Schools' Enrollment Center located at 2819 S New Haven, Tulsa, OK, 74114.

Upon discharge or release your child may be returning to a conventional classroom. Should you enroll your child in a Tulsa Public School location, we would like to offer your child our continued services to help make the transition back to school as smooth as possible. We can offer support when enrolling, or re-enrolling, in your next TPS facility. We are available to work with teachers to set up a supportive environment for your child. If your child has been previously identified as special needs then we can also collaborate with staff to update special education paperwork.

Please understand we are required to maintain the same level of confidentiality concerning information about your child. Often schools contact us regarding a transition meeting, therefore, you may be hearing from a Tulsa Public Schools representative. If you have not heard from anyone and would still like to utilize this service please contact one of the following people.
Thank you.

Geoff Wilbur
918-746-6309 office
wilbuge@tulsaschools.org

Vicki Campbell
918-833-8376 office
campbvi@tulsaschools.org

Tulsa Public Schools Enrollment Form

Site: 621 Entry Date: Exit Date:

Name of Person completing this form:		
Phone Number of Person completing this form:		
Last Name (from birth certificate):	First Name (from birth certificate):	Middle Name (from birth certificate):
Student's Birthplace - City, State:	**Student's** Date of Birth	**Student's** Age & current grade level Age: _____ Grade: _____
Social Security Number	Mother's name (from birth certificate):	Mother's Maiden Name:
Ethnicity - Hispanic/Latino origin? Cirlce one: Yes or No	Race (check all that apply) Black ☐ White ☐ American Indian/Alaskan native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐	
Student lives with: (Circle One) Both parents Mother Father court guardian/DHS Other		Gender (circle one) Male Female
Does the student receive Medicaid Benefits? Yes No		
Last School attended/Name:	City:	State:
Name of Parent/Guardian #1	Home Address: Street	Home Address: City, State, Zip
Home Phone:	Cell Phone:	email:
Name of Parent/Guardian #2		
Home Phone:	Cell Phone:	email:

Is the parent/guardian serving on active duty in the military?	Circle one: Yes	No
Is the parent/guardian a Military Reserve member?	Circle one: Yes	No
Is the parent/guardian a National Guard member?	Circle one: Yes	No

Are there any protective orders, guardianship, or custody issues the district needs to document?
Yes No If yes, please provide a cerified copy of the court order.

Is this a DHS placement? Yes No If yes, provide the KK # & caseworker name/number

Is the student currently served via an IEP?	Yes	No
Is the student currently served via an ELL?	Yes	No
Is the student currently served via a 504 plan?	Yes	No

The Family Educational Rights and Privacy Act requires that the School District, with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, the School District may disclose appropriately designated "directory information" without written consent, unless you have advised the District to the contrary in accordance with District procedures. The primary purpose of directory information is to allow the School District to include this type of information from your child's education records in certain school publications or to outside organizations without a parent's prior written consent. Directory information includes: Student Name, address, phone number, grade level, and school of enrollment.

Do you allow the district to share with the military?	Yes	No
Do you allow the district to share with anyone?	Yes	No
Do you allow the district to share only for school purposes (yearbook, school pictures)?	Yes	No

Your Name (please print): _____ Signature: _____

Tulsa Public Schools Enrollment Form

Site: 621 Entry Date: Exit Date:

Nombre de la persona ques esta llenando este formulario:		
Numero de telefono de la persona que esta llenando este formulario:		
Apellido del alumno (como esta en la acta):	Primer Nombre del alumno (como esta en la acta):	Segundo Nombre del alumno (como esta en la acta):
Lugar de nacimiento del estudiante - Cuidad, Estado:	Fecha de nacimiento del estudiante:	El grado y edad actual del alumno: Edad:_____ Grado: _____
Numero de seguro social:	Nombre de la madre(come esta en la acta):	Apellido de sotera de la madre:
Origen etnico - Hispano/Origen latino? Encierre en un círculo: Si o No	Raza (marque todas los que correspondan) Negro ☐ Blanco ☐ Indio Americano o Nativo de Alaska ☐ Asiatico ☐ Nativo de Hawái u otra isla del pacifico ☐	
El alumno vive con: (encierre en un círculo) Ambos padres Madre Padre Tutor asignado por la corte/DHS Otro		Género: (encierre en un círculo) *Masculino* *Femenino*
Recibe beneficios de Medicaid el alumno? Si No		
Nombre de la ultima escuela en la que estuvo:	Cuidad:	Estado:
Nombre del padre o Tutor legal #1	Dirrecion de la casa: Calle	Dirrecion de la casa: Cuidad, Estado, Codigo Postal
Teléfono de casa:	Numero de celular:	Correo electronico:
Nombre del padre o Tutor legal #2		
Teléfono de casa:	Numero de celular:	Correo electronico:
Is the parent/guardian serving on active duty in the military?		Circle one: Yes No
Is the parent/guardian a Military Reserve member?		Circle one: Yes No
Is the parent/guardian a National Guard member?		Circle one: Yes No
¿Hay órdenes de protección, tutela o problemas de custodia que necesita documentar el distrito? Yes No	Si éste es el caso, por favor proporcione una copia certificada de la orden del juzgado.	
Is this a DHS placement? Yes No	Si este es el caso, por favor proporcione el # KK y el nombre y numero de la trabajadora social.	
¿El alumno recibe servicios a través de un IEP ? Si No		
¿Recibe servicios a través de un ELL el alumno? Si No		
¿El alumno recibe servicios a través de un plan 504? Si No		

La Ley de Privacidad y Derechos Educativos de la Familia requiere que el Distrito Escolar, con ciertas excepciones, obtenga su consentimiento por escrito antes de revelar la información de identificación personal de los registros educativos de su hijo. Sin embargo, el Distrito Escolar puede divulgar la "información del directorio" designada apropiadamente sin el consentimiento por escrito, a menos que haya avisado al Distrito de lo contrario de acuerdo con los procedimientos del Distrito. El propósito principal de la información del directorio es permitir que el Distrito Escolar incluya este tipo de información de los registros educativos de su hijo en ciertas publicaciones escolares o en organizaciones externas sin el consentimiento previo por escrito de los padres. La información del directorio incluye: Nombre del estudiante, dirección, número de teléfono, nivel de grado y escuela de inscripción.

¿Permite que el distrito comparta su informacion con el ejército? Si No

¿Permite que el distrito comparta su informacion con quien sea? Si No

¿Permite que el distrito comparta solo para fines escolares (anuario, fotos escolares)? Si No

Nombre (letra minúscula): _____ Firma: _____

Facility Name Parkside

Site # 621

TULSA PUBLIC SCHOOLS

EQUITY CHARACTER EXCELLENCE TEAM JOY

CONSENT FOR THE RELEASE OF EDUCATIONAL RECORDS

Student's Name	SS#	DOB	Grade

The undersigned hereby authorizes school #1 _____
Name and address of previous school

The undersigned hereby authorizes school #2 _____
Name and address of previous school

The undersigned hereby authorizes school #3 _____
Name and address of previous school

to disclose to Tulsa Public Schools and our facilities the following information: **Transcript, withdrawal grades, quarterly grades, immunization records, special education records and other pertinent testing/information concerning the above named child.**

The purpose of this disclosure is for appropriate educational placement and programming at Tulsa Public Schools Facilities.

I/We also do hereby give permission for this child's Tulsa Public Schools and the above listed facilities records to be released to his/her placement after discharge for the purposes of assisting in appropriate educational programming.

I/We also hereby give permission for Tulsa Public Schools to release information in their files to the facility listed above and the above listed facility to release information in their files to the Tulsa Public School Department which would help in evaluating and recommending present and future programming.

The above has been explained and agreed to by me.

Parent/Authorized Legal Representative	Relationship	Date

Witness Signature	Title	Date

Education records are maintained and released in accordance with the Family Educational Rights and Privacy Act (FERPA). Parents or eligible students shall be provided a copy of the records to be disclosed if requested. Further disclosure of the above records will be in accordance with 34 CRF 99.31

2019 – 2020

HOME LANGUAGE SURVEY FOR PRE-K-12 SCHOOL DISTRICTS

EDUCATION

STUDENT INFORMATION

Name of Student: _____ Grade: _____
Last Name First Name Middle Name

Date of Birth: _____ School: 621 Student ID # _____ Gender: Male_____ Female_____
MM/DD/YYYY

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/Alaskan Native _____ Asian
_____ Native Hawaiian/Pacific Islander _____ Caucasian/White

1. What is the dominant language **most often** spoken by the student? _____
2. What is the language **routinely** spoken in the home, regardless of the language spoken by the student? _____
3. What language was **first** learned by the student? _____
4. Does the parent/guardian need **interpretation** services? Yes _____ No _____ If so, what language? _____
5. Does the parent/guardian need **translated** materials? Yes _____ No _____ If so, what language? _____
6. What was the date the student first enrolled in a school in the United States? _____
MM/YYYY

_____
Date (MM/DD/YYYY) Parent / Guardian Signature

SCHOOL USE ONLY

Please have test score documentation available for the Regional Accreditation Officer to review.

☐ **Other language than English indicated TWO OR MORE times on questions 1 – 3 above.** The student is classified as "more often" and automatically qualifies as **bilingual** on the accreditation report.

☐ **Other language than English indicated ONLY ONCE on questions 1 – 3 above.** The student is classified as "less often" and only qualifies as **bilingual** on the accreditation report *if* **he or she meets one of the following** (any selection below REQUIRES appropriate documentation):

☐ 1. Designated English Learner on one of the Oklahoma English language proficiency assessments: ACCESS for ELLs 2.0, Alternate ACCESS for ELLs, WIDA Screener, WIDA MODEL, K-WAPT, W-APT or Oklahoma Pre-K Language Screening Tool.
☐ 2. Scored unsatisfactory or limited knowledge in Reading on the Oklahoma State Testing Program (OSTP).
☐ 3. Scored at or below the 35th percentile (or equivalent) composite reading score from spring of the previous school year on a state approved norm-referenced test (NRT).

DOCUMENTATION OF A TEST RESULT FOR STUDENTS MARKED LESS OFTEN

Date(s) of Kindergarten ACCESS, ACCESS for ELLs 2.0, or Alternate ACCESS Test	*Score(s) on Kindergarten ACCESS, ACCESS for ELLs 2.0,or Alternate ACCESS*		*Date(s) of WIDA Screener or K-WAPT/WAPT or WIDA MODEL*	*Score(s) on WIDA Screener or K-WAPT/WAPT or WIDA MODEL*	
	Composite Score	*Literacy Score*		*Composite Score*	*Literacy Score*
	1.	2.		1.	2.
	1.	2.			

Date(s) of Reading OSTP	Score(s) on Reading OSTP							
		Unsatisfactory		Limited Knowledge		Satisfactory		Advanced
		Unsatisfactory		Limited Knowledge		Satisfactory		Advanced
		Unsatisfactory		Limited Knowledge		Satisfactory		Advanced

Date of the Oklahoma Pre-K Language Screening Tool	Score on Pre-K Language Screening Tool
	%

Date(s) Norm Reference Test (NRT)	Name of the NRT	Reading Total Composite Score(s) %

From Above:
Question 1: Reference WAVE code 1036
Question 2: Reference WAVE code 1037
Question 3: Reference WAVE code 1038

ENCUESTA DEL IDIOMA QUE SE HABLA EN CASA PARA LOS DISTRITOS ESCOLARES CON GRADOS DE PRE-KÍNDER AL 12

2019 – 2020

EDUCATION

INFORMACIÓN DEL ALUMNO

Nombre del alumno: _____ # de estudiante _____
Apellido Primer nombre Segundo nombre

Sexo: Masculino _____ Femenino _____ Fecha de nacimiento: _____ Escuela: 621

Seleccione una o más de las siguientes razas:
_____ Afro Americano/Negro _____ Indigena de Estados Unidos/Nativo de Alaska _____ Asiático
_____ De origen Hawaiano/Isleño del Pacifico _____ Caucásico/Blanco _____ Otra

¿Es el alumno de cultura u origen hispano o latino? Sí: _____ No: _____

1. ¿Qué idioma habla con **más frecuencia** el alumno? _____
2. ¿Cuál es el **principal idioma** que se habla en casa, independientemente del idioma que habla el alumno? _____
3. ¿Cuál fue el **primer** idioma que aprendió a hablar el alumno? _____
4. ¿El padre o tutor necesita servicios de **interpretación**? Sí _____ No _____ Si es así, ¿en qué idioma? _____
5. ¿El padre o tutor necesita materiales **traducidos**? Sí _____ No _____ Si es así, ¿en qué idioma? _____
6. ¿En qué fecha (**mes y año**) inscribió a su hijo por primera vez en una escuela de Estados Unidos? _____

_____
Firma del padre o tutor Fecha

SCHOOL USE ONLY

Please have test score documentation available for the Regional Accreditation Officer to review.

☐ Other language than English indicated TWO OR MORE times on questions 1 – 3 above. The student is classified as "more often" and automatically qualifies as **bilingual** on the accreditation report.

☐ Other language than English indicated ONLY ONCE on questions 1 – 3 above. The student is classified as "less often" and only qualifies as **bilingual** on the accreditation report *if* he or she meets one of the following (any selection below REQUIRES appropriate documentation):

☐ 1. Designated English Learner on one of the Oklahoma English language proficiency assessments: ACCESS for ELLs 2.0, Alternate ACCESS for ELLs, WIDA Screener, WIDA MODEL, K-WAPT, W-APT or Oklahoma Pre-K Language Screening Tool.

☐ 2. Scored unsatisfactory or limited knowledge in Reading on the Oklahoma State Testing Program (OSTP).

☐ 3. Scored at or below the 35th percentile (or equivalent) composite reading score from spring of the previous school year on a state approved norm-referenced test (NRT).

DOCUMENTATION OF A TEST RESULT FOR STUDENTS MARKED LESS OFTEN

Date(s) of Kindergarten ACCESS, ACCESS for ELLs 2.0, or Alternate ACCESS Test	*Score(s) on Kindergarten ACCESS, ACCESS for ELLs 2.0,or Alternate ACCESS*		*Date(s) of WIDA Screener or K-WAPT/WAPT or WIDA MODEL*	*Score(s) on WIDA Screener or K-WAPT/WAPT or WIDA MODEL*	
	Composite Score	*Literacy Score*		*Composite Score*	*Literacy Score*
	1.	2.		1.	2.
	1.	2.			

Date(s) of Reading OSTP	Score(s) on Reading OSTP							
		Unsatisfactory		Limited Knowledge		Satisfactory		Advanced
		Unsatisfactory		Limited Knowledge		Satisfactory		Advanced
		Unsatisfactory		Limited Knowledge		Satisfactory		Advanced

Date of the Oklahoma Pre-K Language Screening Tool	Score on Pre-K Language Screening Tool
	%

Date(s) Norm Reference Test (NRT)	Name of the NRT	Reading Total Composite Score(s) %

From above:
Question 1: Reference WAVE code 1036
Question 2: Reference WAVE code 1037
Qutestion 3: Reference WAVE code 1038

TULSA PUBLIC SCHOOLS

Tulsa Public Schools

EQUITY CHARACTER EXCELLENCE TEAM JOY

Student Name _____ Site - Parkside Site 621

By signing my name below, I am affirming that I have reviewed the information provided regarding enrollment into Tulsa Public Schools provision of services and that **I am declining enrollment at this time.**

_____

Parent/Authorized Legal Representative Relationship Date

_____

Witness Signature Title Date