SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

BEHAVIORAL HEALTH SERVICES
INTAKE PACKET

Instructions: Please fill in the blanks/check the boxes for each question. **Do not leave anything blank.**

Client Information **Please answer all questions**

Full Legal Name:		DOB:		Ht:		Wt:	
Preferred Name:		Sex: ☐M ☐F ☐Other:_____					
Other Names:		Home Phone:					
Email:		Cell Phone:					
Physical Address (Include city, state, zip) :							
If Different, Mailing Address (Include city, state, zip):							
Primary Language:		Interpreter Required: ☐ Yes ☐ No					
FOR YOUTH ADMISSIONS, list legal guardian(s):							

(Note to staff: If legal custody of minor client is shared, or if the legal guardian is not a natural or adoptive parent, collect legal custody documents)

Source of referral *(who referred you here):*	
Preferred method for receiving appointment reminders *(select only one):*	☐ Text ☐ Call
Do you have internet access?	☐ Yes ☐ No
Do you feel comfortable using the internet?	☐ Yes ☐ No
Where can you access the internet?	☐ Home ☐ Work ☐ Library ☐ School ☐ Phone
Have you received mental health, substance use, or psychiatric services in the past? ***(Note to staff: If yes, ask if we can request records and have client complete ROI)***	☐ Yes ☐ No
Do you have an Advance Psychiatric Directive? ***(Note to staff: If yes, ask if we can have a copy of it for our records; if no (and an adult) ask if they would like information about obtaining one)***	☐ Yes ☐ No
Describe why you are seeking services:	

Emergency Contacts **Please list at least one emergency contact**

Name	Phone Number(s)	Relationship to Client

Insurance Information **Please answer all questions** ☐ No Insurance ☐ Copy of Insurance Card(s)

Primary Insurance Company	Insurance Company Phone Number
Subscriber ID number	Group or Plan
Subscriber Name	Subscriber Social Security Number
Subscriber Date of Birth	Relationship to Recipient
Secondary Insurance Company	Insurance Company Phone Number
Subscriber ID number	Group or Plan
Subscriber Name	Subscriber Social Security Number
Subscriber Date of Birth	Relationship to Recipient
Other Insurance:	

Admission Type (Staff Use Only): ☐ First Admission ☐ Re-Admission

Tuberculosis, HIV/AIDS, Fetal Alcohol Spectrum Disorder, Hepatitis C
Information Sheet

HIV/AIDS:

- AIDS (Acquired Immune Deficiency Syndrome) reduces the body's ability to fight disease, eventually resulting in death from infections that the body cannot fight off.
- HIV (Human Immunodeficiency Virus) is the virus causing AIDS. It destroys white blood cells, which guard the body from infection.
- HIV is carried in blood, semen, and vaginal fluids.
- The following behaviors put you at risk for HIV/AIDS: Sharing needles contaminated with HIV, having sex with an infected person, sex with multiple partners, and receiving contaminated blood. It can also be spread to a child through pregnancy and breast feeding, if the mother has HIV.
- Alcohol and drug use put you at risk for getting AIDS through poor choices about sexual activity and needle use.
- To avoid HIV, use latex or polyurethane condoms and do NOT engage in high-risk behaviors.

Tuberculosis:

- The State of Alaska is targeting tuberculosis (TB) screening of high-risk populations. For example, Alaska Natives, diabetics, and those taking immunosuppressive therapy. TB is a major public health concern in the State of Alaska.
- Some symptoms suggesting TB are cough, fever, difficulty breathing, loss of appetite and fatigue.
- Some people can have a positive skin test but have no clinical evidence of TB and are not infectious. This is called a latent tuberculosis infection (LTBI). Persons with LTBI are at greater risk of developing TB.

Fetal Alcohol Spectrum Disorder:

- Fetal Alcohol Spectrum Disorder (FASD) is a birth defect caused by the mother drinking during pregnancy. Prenatal alcohol exposure can result in a child affected by alcohol.
- Alcohol use during pregnancy puts you at risk of having a child with Fetal Alcohol Spectrum Disorder (FASD).
- Prenatal alcohol exposure may be the number one cause of developmental disability in the nation.
- Children with FASD are smaller than normal in height, weight, and size of head, and they never catch up. Prenatal exposure to alcohol may result in serious learning and adjustment problems which are very difficult to correct. Parenting a child with FASD can be a very difficult, demanding, and exhausting experience.
- FASD is completely preventable by not drinking alcohol during pregnancy.
- Male partners of pregnant women have an important role in supporting the abstinence of the pregnant women.

Hepatitis C:

- Hepatitis C is most often passed from one person to another through infected blood. It can also be passed through sexual intercourse.
- Serious health problems can develop over time as a result of Hepatitis C. These may include liver cancer or cirrhosis.
- Be safe: don't share needles, toothbrushes, or razors. Use safer sex practices: abstain, have one lifetime monogamous partner, or use a new latex condom every time you have sex.

Optional: Please indicate below if you would like to receive a referral or testing for any of the following:

☐ HIV/AIDS ☐ Tuberculosis ☐ FASD ☐ Hepatitis C

Physical Health

Please check the boxes below if you have or have ever had the following:

	Treated	Untreated		Treated	Untreated
Anemia or blood disorder	☐	☐	High or low blood sugar	☐	☐
Rheumatic or scarlet fever	☐	☐	Head injury	☐	☐
Shortness of breath, COPD, or Emphysema	☐	☐	If yes, when?		
			Blood in urine or stool	☐	☐
Chest pains	☐	☐	Frequent illness	☐	☐
Fainting spells	☐	☐	Heart trouble	☐	☐
Kidney disease or bladder infection	☐	☐	Glaucoma	☐	☐
Liver disease-hepatitis or cirrhosis	☐	☐	Frequent headaches	☐	☐
Cancer	☐	☐	HIV/AIDS	☐	☐
Diabetes	☐	☐	Other Sexually Transmitted Infection	☐	☐
Tuberculosis	☐	☐	Epilepsy/Seizure Disorder	☐	☐
Recent sleep difficulties	☐	☐	Allergies (food, drug or other)	☐	☐
Ulcers or pains in the stomach	☐	☐	If yes, list:		
Numbness in any part of your body	☐	☐			

Note to Staff: Any item "untreated" = Referral

Current medications: prescription, Over the Counter (OTC), herbal ☐No current medications

Name & Strength/Quantity	Times Taken	Reason Taken	Concerns about effectiveness?	Complications or side effects
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Note to Staff: Concerns about effectiveness = Referral to prescribing physician

How would you rank your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unsure (***Note to Staff: Poor or Unsure=Referral)***

1. Do you have a current physical illness other than withdrawal that will complicate treatment? (***Note to Staff: Yes= Referral if untreated)*** ☐Yes ☐ No ☐Unknown

   If yes, please specify:

2. Are you current on your immunizations? ☐Yes ☐ No ☐Unknown

3. Any chronic medical conditions or accidents for which you have received treatment? ☐ Yes ☐ No

   If yes, please specify dates and conditions:

4. Do you need have a visual or hearing impairment that would require accommodations? ☐ Visual ☐ Hearing ☐ No

5. Do you need (or have you had) an evaluation for mobility difficulties? ☐ Yes ☐ No

6. Are you pregnant? ☐ Yes ☐ No ☐ Unknown ☐ N/A

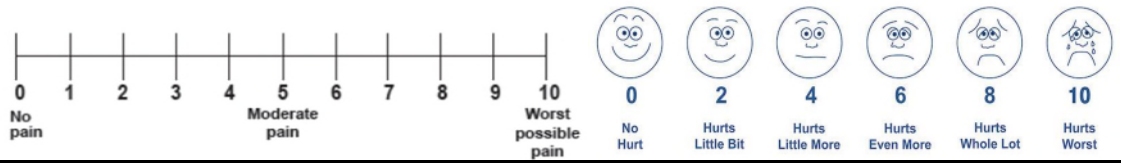
   If yes, due date:

Patient Name: Patient DOB:

NUTRITION Please check the boxes below if you are experiencing the following:
☐ Decrease in food intake due to poor appetite, digestive problems, chewing or swallowing problems Details:
☐ Dental pain or concerns Details:
☐ Concerning eating behaviors such as bingeing or inducing vomiting Details:
☐ Unintentional weight loss of >9 pounds in the past 3 months
☐ Unintentional weight gain of >9 pounds in the past 3 months

Note to Staff: Any items marked= Referral

PAIN



Are you currently in pain? Yes ☐ No ☐		
If yes…	Where is the pain located?	
	What is the frequency of the pain?	☐ Constant ☐ Intermittent (not constant; off and on)
	From the scale listed above, what is the severity of the pain?	
	Are you actively receiving treatment for your pain? Yes ☐ No ☐	
	Do you feel that pain is impacting your quality of life? Yes ☐ No ☐	

Note to Staff: Untreated pain that impacts quality of life = Referral

Have you seen a medical provider within the past year? ☐ Yes ☐ No **(*Note to Staff: No=Referral*)**

Physician's/Clinic's Name: _____ City_____

1. Do you plan to take or think you need a new medication for psychiatric purposes?	☐ Yes ☐ No
2. Do you plan to take or think you need medication for Opioid Use Disorder treatment?	☐ Yes ☐ No
(Note to Staff: Yes to 1 or 2 above = Referral)	
3. Are you currently or have you in the past engaged in injection drug use?	☐ Yes ☐ No

Current Use of Tobacco (*Check one):*

☐ Cigarettes ☐Cigars/Pipes ☐Combination ☐Elec. Cigarettes ☐Smokeless Tobacco ☐Other ☐None

(Note to staff: Any tobacco use = Referral to the Tobacco Quitline)

Staff use only: Was client referred for services?				
Pain Assessment	Nutrition Assessment	Dental	Medical	Tobacco Quit Line
☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined
Notes:				

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BEHAVIORAL HEALTH SERVICES

ATTENDANCE PROCEDURE

Welcome to SEARHC Behavioral Health. We are proud to partner with you and assist you in achieving the best possible outcomes for your personal health and well-being.

SEARHC Behavioral Health has a high demand of requests for clients who are in need and waiting to receive services. We believe everyone has the right to receive services in a timely fashion thus we have a current attendance/no show protocol to try to make our services accessible.

1. Please provide 24-hour notice if you plan to miss an appointment. An appointment is also considered missed if you are more than 15 minutes late without notifying the clinic.
   With input from your clinician:
   - *After 2 documented missed appointments within 90 days, your status can be changed to "same-day only"*
   - *After 2 documented successful efforts to come, your "same-day only" status will be removed*

2. The Initial Assessment appointment is a required appointment to begin services. Calling to cancel is essential to keeping your case open. When the Initial Assessment appointment is missed it can be rescheduled with advanced notice.
   - 2 missed Initial Assessment appointments will result in your referral being closed and you will be required to re-start the referral process.

3. Alcohol Safety Action Program (ASAP) or court referred clients are considered non-compliant if they miss appointments, this can result in a letter of non-compliance being issued to the court or ASAP.

4. A letter will be sent to clients prior to their case being closed due to no-shows. Clients who have not seen their provider for 90 days will have their case closed.

5. Medication prescriptions and refills may not be continued if you do not keep your scheduled medication appointments. Regular medical review is required to provide ongoing medication. If you become ineligible for ongoing medications due to lack of review with the prescriber, we will notify you by phone or writing. The date of your last access to medication will be given so that you can make other arrangements if you choose.
   - If you miss two consecutive appointments your prescriptions will only be extended to the next scheduled appointment. If that appointment is not kept, you will need to make and keep an appointment with us before medication can be restarted by us

By signing this procedure, I acknowledge that I understand and will comply with the attendance protocol to ensure that communication about my care, schedules, and needs for services are clear.

_____ _____

Printed Name of Client Client DOB

_____

Signed by responsible party (Client, Parent, Guardian)

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BEHAVIORAL HEALTH SERVICES

CONSENT FOR TREATMENT

Welcome to SEARHC Behavioral Health Services. We offer both outpatient treatment and residential treatment that include individual, group and family counseling, psychopharmacology, psychological testing as well as education, prevention, and referral services. Your provider will work with you to develop and implement a treatment plan to address your unique needs. With your approval, members of your family may be involved in your treatment. Your active involvement, understanding and commitment to your treatment are an essential component.

To provide you with the very best care, your clinical information is disseminated and provided to other SEARHC health providers and personnel on a "need to know basis." This would include your SEARHC Behavioral Health provider, other SEARHC medical providers, and referral agents in your home community. This is a best practice for assuring that both your present and future treatment goals/needs are properly communicated and addressed. Some psychotherapy, counseling, and substance abuse information has additional protections and requires additional permission from you to be shared.

Responsibilities:

1. To provide accurate and complete information regarding your history and health status.
2. To review the SEARHC Behavioral Health Handbook (available online and in printed form up on request).
3. To ask questions about anything you don't understand.
4. To fully attend and actively participate in treatment. By signing this document, you are agreeing to actively work with your provider, to help develop your treatment plan and to follow through with your plan of care.
5. To comply with the SEARHC tobacco-free, drug-free, and violence-free policies.
6. To treat other clients and staff with respect and courtesy.
7. To share your end-of-life plans if you are incapacitated with SEARHC staff if applicable.
8. To request another provider if you feel you cannot successfully establish a working relationship with your assigned provider.
9. To tell your provider directly if you plan to discontinue your treatment.
10. To actively participate in developing a discharge plan as you proceed through treatment.
11. To provide up-to-date registration information, including insurance changes.
12. To allow Behavioral Health staff to contact you by mail or telephone following completion of this treatment, to follow up on the services you have received and to identify if there is a need for additional support.
13. To be responsible for keeping appointments and cooperating with staff to assure continuity of care. Notify your provider immediately if you are unable to keep an appointment and reschedule a future appointment.
14. To comply with SEARHC staff requests for Urinalysis Assessment (UA), medication review, and blood tests when required by the treatment protocol.

In the event of an emergency, I authorize SEARHC Behavioral Health to utilize my emergency contacts on file.

By my signature entered below, I hereby give consent for treatment, establish my responsibility for participation, authorize reminders, notices of other health related benefits, and follow-up, and acknowledge the receipt of the above information. My signature confirms my agreement with the entire page. I have received a copy of this form. I have been offered a copy of the SEARHC Behavioral Health Handbook.

_____ _____

Printed Name of Client Client DOB

_____

Signed by responsible party (Client, Parent, Guardian)