

CLIENT VOLUNTARY REGISTRATION QUESTIONNAIRE

NAME: _____

SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (_____) _____ BIRTH PLACE: CITY: _____ STATE: _____

GENDER:

MALE

FEMALE

ETHNICITY:

CUBAN

HAITIAN

MEXICAN

PUERTO RICAN

OTHER HISPANIC

NONE OF ABOVE

MARITAL STATUS:

NEVER MARRIED

MARRIED

WIDOWED

DIVORCED

SEPARATED

EMPLOYMENT:

DISABLED

FULL TIME

HOME MAKER

PART TIME

RETIRED

STUDENT

UNEMPLOYED

RACE:

ASIAN

BLACK

HISPANIC

MULTI RACIAL

NATURAL HAWAIIAN

WHITE

HOW MANY CHILDREN DO YOU HAVE? _____ DO THEY LIVE WITH YOU? YES / NO

HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD? _____ EDUCATION LEVEL _____

DO YOU RECEIVE: SOCIAL SECURITY INSURANCE YES / NO

SOCIAL SECURITY DISABILITY INSURANCE YES / NO

DO YOU HAVE ANY ADVANCE DIRECTIVES: LIVING WILL YES / NO

HEALTH CARE SURROGATE YES / NO

DO YOU HAVE ANY HEARING LOSS? YES / NO

IF YES, HOW DO YOU PREFER TO COMMUNICATE? _____

PRIMARY LANGUAGE: _____ HAVE YOU EVER SERVED THE US MILITARY: YES / NO

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: (_____) _____

RELEASE OF INFORMATION

WOULD YOU LIKE TO SIGN A RELEASE OF INFORMATION FOR YOUR EMERGENCY CONTACT OR A DIFFERENT PERSON SO THAT STAFF WILL BE ABLE TO SPEAK WITH THAT PERSON AND ACKNOWLEDGE YOUR ADMISSION TO INTAKE AND EVALUATION? YES / NO

IF YES, NAME OF PERSON: _____ PHONE: (_____) _____

RELATIONSHIP: _____

DO YOU HAVE ANY HEALTH INSURANCE: YES / NO

IF YES, WHAT KIND: _____

Application for Voluntary Admission of an Adult (Receiving Facility)

I, _____ do hereby apply for admission to
Full printed name of person whose admission is being requested

Fill in name of facility South County Mental Health Center, Inc.

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:

I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning my medical or mental health treatment. I do not have a guardian, guardian advocate, or currently have a health care surrogate/proxy making health care decisions for me.

I ☐ have ☐ have not provided a copy of advance directive(s).

If so, the advance directives include my:

- ☐ Living Will
☐ Health Care Surrogate,
☐ Mental Health Care Surrogate,
☐ Other as specified:

I have been provided with a written explanation of my rights as a person on voluntary status and they have been fully explained to me. **I understand that this facility is authorized by law to detain me without my consent for up to 24 hours after I make a request for discharge;** unless a petition for involuntary inpatient placement or involuntary outpatient placement is filed with the Court within two (2) court working days of my request for discharge in which case I may be held pending a hearing on the petition.

I understand that I may be billed for the cost of my treatment.

Signature of Competent Adult _____ Date _____ Time _____ am pm

Printed Name of Witness _____ Signature of Witness _____ Date _____ Time _____ am pm

No notice of this admission is to be made without the consent of the person except in case of an emergency. The use of this form for a voluntary admission requires that a "Certification of Person's Competence to Provide Express and Informed Consent" be completed within 24 hours and if the form is used for a transfer of a person from involuntary to voluntary status, the "Certification" must be completed prior to the "Application". The "Application" and "Certification" must be placed in the person's clinical record.

General Authorization for Treatment Except Psychotropic Medications

I, the undersigned, a ☐ competent adult, ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy hereby authorize the professional staff of this facility to administer assessment and treatment specified below. I understand that I am in a facility where medical, nursing, and behavioral health students train under the supervision of a professional staff.

- ☐ Routine medical care _____ (Initials of Person or Authorized Decision Maker)
- ☐ Psychiatric Assessment _____ (Initials of Person or Authorized Decision Maker)
- ☐ Other (Specify & Initial) _____
- _____
- _____

I understand that more information will be provided to me before my informed consent will be requested for the administration of any psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

Signature of Competent Adult _____ Date _____ Time _____ am pm

Signature of Witness for Person _____ Date _____ Time _____ am pm

Signature of: (check one when applicable) _____ Date _____ Time _____ am pm

☐ Guardian ☐ Guardian Advocate

☐ Health Care Surrogate ☐ Health Care Proxy

If I am the guardian advocate, health care surrogate, or health care proxy for the person, I certify that I have met and talked with the person and the person's physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form.

Talked to person on: _____ (date) ☐ In person ☐ By telephone. If not in person, explain why not. _____

Talked to person's physician on: _____ (date) ☐ In person ☐ By telephone. If not in person, explain why not. _____

Signature of: (check one when applicable) _____ Date _____ Time _____ am pm

☐ Guardian ☐ Guardian Advocate

☐ Health Care Surrogate ☐ Health Care Proxy

Signature of Witness for Substitute Decision-Maker _____ Date _____ Time _____ am pm

The person shall always be asked to sign this authorization form. However, if the person is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if an individual other than the person signs the consent to treatment. The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization.

Part I
Notice of Right of Person on Voluntary Status
To Request Discharge From a Receiving Facility

A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by a person other than the person, the discharge may depend on the express and informed consent of the person.

If you request discharge, your doctor will be notified and you will be discharged within 24 hours after your request for discharge unless you withdraw your request or you meet the criteria for involuntary inpatient placement or involuntary outpatient placement. If you meet the criteria for involuntary inpatient or outpatient placement, the facility administrator may file a petition with the court for your continued detention within two (2) court working days and you will be detained without your consent, pending a court hearing.

If you wish to request discharge at any time during your stay at this facility, complete the Application for Discharge on the reverse side of page. No action on your part is required, unless you wish to make arrangements for release.

The procedure for requesting discharge has been explained to me and I have had the opportunity to ask questions and receive answers about my right to request discharge.

Printed Name of Person	Signature of Person	Date	Time _____ am pm
Printed Name of Guardian of Minor	Signature of Guardian of Minor	Date	Time _____ am pm
Printed or Typed Name of Witness	Signature of Witness	Date	Time _____ am pm

cc: Check when applicable and provide date/time/initial when copy provided:

☐ Person	Date:	Time: _____ am pm	Initial:
☐ Guardian of Child	Date:	Time: _____ am pm	Initial:

Parts II and Part III are continued

Part II Application for Discharge

Pursuant to Section 394.4625 (2), Florida Statutes, I, _____
hereby apply for my release or that of _____
who is a voluntary patient at (Name of Facility) South County Mental Health Center, Inc.
My relationship to the said person is that of (Relationship) _____

Signature of Person or Authorized Individual on his or her behalf Date _____ Time _____ am pm

An oral request for discharge was made by _____ on _____
Name of Requester Date Time _____ am pm

Signature of Staff Printed Name of Staff _____ Date _____ Time _____ am pm

If this request for discharge was made by someone other than me, I concur with the above request for my discharge. If not, I have completed Part III below.

Signature of Adult Date _____ Time _____ am pm

Signature of Guardian of Minor Date _____ Time _____ am pm

Signature of Witness Date _____ Time _____ am pm

cc: Check when applicable and date/time/initial when copy provided:

☐ Person	Date: _____	Time: _____ am pm	Initials: _____
☐ Guardian of Minor	Date: _____	Time: _____ am pm	Initials: _____

Part III Withdrawal of Application for Discharge

I, _____, freely and voluntarily rescind my previous oral or written Application for Discharge or do not concur with the request for discharge made by another person. No force, fraud, deceit, duress, or other form of constraint or coercion were used to obtain this withdrawal of my Application for Discharge.

Signature of Person Date _____ Time _____ am pm

Signature of Witness Credentials of Witness _____ Date _____ Time _____ am pm

cc: Check when applicable and date/time/initial when copy provided:

☐ Person	Date: _____	Time: _____ am pm	Initials: _____
☐ Guardian of Minor	Date: _____	Time: _____ am pm	Initials: _____

Rights of Persons In Mental Health Facilities and Programs

Before any treatment is given to you, you will be given information about the proposed treatment, the purpose of the treatment, the common side effects of medication you receive, alternative treatments, the approximate length of care and that any consent given may be revoked at any time by you, your guardian, your guardian advocate or your health care surrogate/proxy. There are additional disclosures that must be made for medications you receive. If the treatment for which you have given consent is changed at any time during your stay in this facility, it will be fully explained by the staff prior to asking for your written consent to the revised treatment.

You have the right to keep your clothing and personal effects unless they are removed for safety or medical reasons. If they are taken from you, an inventory of the possessions will be prepared and given to you to sign. The possessions will be immediately returned to you or your representative upon your discharge or transfer from this facility.

You or your representative has the right to ask the Court to review the cause and legality of your detention in this facility or if you believe you have been unjustly denied a legal right or privilege or an authorized procedure is being abused. A petition form will be given to you by staff upon your request. If you wish to file a habeas corpus petition, you can submit it to a facility staff member and it will be filed with the court for you by the facility no later than the next court working day.

You have the right to register to vote and to cast your vote in any elections unless the court has removed this right from you. Staff will assist you in arranging for registration or voting.

You have the right to seek treatment from the professional agency of your choice after your discharge from this facility.

Signature, if applicable, of ☐ Guardian ☐ Guardian Advocate ☐ Representative ☐ Health Care Surrogate/Proxy Date _____ Time _____ am pm

This form must be retained in the clinical record as a receipt that the person received notice of his/her rights at the time of admission. A copy must be given to the person and to any authorized decision-maker for persons incompetent or incapacitated by age or disability.

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Health Care Surrogate/Proxy		am pm	

Client's Printed Name

Client's HIM number

**SOUTH COUNTY MENTAL HEALTH CENTER, INC.
16158 SOUTH MILITARY TRAIL
DELRAY BEACH, FLORIDA 33484**

PRIVACY ACKNOWLEDGEMENT FORM

I, the undersigned, acknowledge that I have received from South County Mental Health Center a privacy notice in accordance with HIPAA guidelines. I understand that South County Mental Health Center will make every effort to protect my personal health information and Healthcare Record in a confidential manner.

Client Signature

Date

Parent/Guardian Signature
(if client is a minor)

Date

Staff Signature/Credentials/ID#

Date

**South County
Mental Health**

CENTER, INC.
16158 S. Military Trail
Delray Beach, Fl. 33484
(561) 495-0522 / 737-8400
Fax (561) 496-5064

**AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED
HEALTHCARE INFORMATION (PHI)**

Client Name: _____

Name at time of treatment (if different from above) _____

Chart #: _____ D.O.B. _____ S.S. #: xxx-xx-_____

I hereby request and authorize To/From (Name of person(s) or agency holding the Information): **South County Mental Health Center, Inc.**

Address: **16158 S Military Trl, Delray Beach, FL 33484**

To release written or verbal mental health and other information specified below:

☐ Admission Summary	☐ TCM Assessment			
☐ Discharge Summary	☐ Medication History	From:	(Date) To:	(Date)
☐ History & Physical	☐ Lab Reports	From:	(Date) To:	(Date)
☐ Psychiatric Evaluation	☐ Progress Notes	From:	(Date) To:	(Date)
☐ Biopsychosocial Evaluation	☐ School Records			
☐ Treatment Plan	☐ Aftercare Plan			☐ Client Status
☐ Narrative Summary	☐ Psychological testing			☐ Verbal Progress Summary
☐ Drug & Alcohol Treatment Records	☐ Intake Assessment			☐ Other: _____

To/ From (Name of person(s) or agency requesting information): _____

Address: _____ Phone Number: _____

For the purpose of: Discharge planning/continuum of care

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR part 2 and HIPAA regulation 45 CFR. There are other special restrictions that apply to the release of information regarding HIV, abuse reports, etc. I also understand that if my medical condition contains treatment notes, diagnosis, or test results of HIV/AIDS and/or related conditions, these records shall also be released. I understand that once the above information is disclosed, then it may not be protected by Federal or State Privacy Laws or Regulations.

I understand that I have the right to refuse to sign this authorization or to rescind my authorization at any time prior to the release of the information. Cancellation will be effective upon the date the notice is received by the provider, but shall exclude information already furnished to the recipient before the date. A general medical authorization and subpoena duces tecum without a specific authorization to release psychiatric information must have this waiver from the client or his/her empowered representative. **In the absence of my written notice, this authorization shall be revoked automatically 1 (one) year after the date of the consent as it appears below. SCMHC recognizes a client's right under HIPAA to access copies of his/her health information except therapy records. There are charges associated with processing and producing requested records.**

FORM(S) IN WHICH INFORMATION IS TO BE RELEASED: ORAL ☒ WRITTEN ☒ FAX ☒
ELECTRONIC (CD, USB, OTHER) Please specify: _____

Expiration Date: _____

Signature of Competent Client	Printed Name of Competent Client	Date (mm/dd/yy)	Time (am/pm)
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When applicable, Signature of: () Guardian, () Guardian Advocate, () Health Care surrogate/proxy or () Personal Representative (if deceased)	Printed Name of Substitute Decision Maker	Date (mm/dd/yy)	Time (am/pm)
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Signature of Witness	Printed Name of Witness	Date (mm/dd/yy)	Time (am/pm)
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I wish to revoke my authorization to release HIM information: Initials _____ **Date** _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected pursuant to 42 CFR part 2, HIPAA regulation 45 CFR, and Florida Statutes 394.4615, and Florida Administrative Code 65E5.250. Any further disclosure is strictly prohibited unless the client provides specific written authorization for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public record law. Date sent out: _____

NATIONAL VOTER REGISTRATION ACT

Preference Form

Client's preference (check the box only in 1, or 2)

If you do not check any box, it will be considered that you chose not to register or update your voter registration at this time.

1. If you are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No, I decline

2. If you are registered to vote where you live now, would you like to update your voter registration record? ☐ Yes ☐ No, I decline

CLIENT PRINT NAME

CLIENT SIGNATURE

DATE

=====Notice of Rights=====

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at <http://election.dos.state.fl.us/nvra/index.shtml> or call 1-850-245-6200 (Authority: National Voter Registration Act (42 U.S.C. 1973gg); sections 97.023, 97.058 and 97.0585, F.S.)

=====

SCMHC Use Only (check all that apply)

(Note: Only a client who is eligible can decline or accept an opportunity to register to update a record on his or her behalf)

- Be a U.S. citizen (a lawful permanent resident cannot register or vote)
- Be at least 18 years old (you may pre-register if you are at least 16 although you cannot vote until you are 18).
- Be a Florida resident
- Have had your right to vote restored if you have ever been convicted of a felony
- Have had your right to vote restored if a court has ever declared you to be mentally incapacitated as to your right to vote

1. Is client eligible to vote? ☐ Yes ☐ No

2. Client applied for: ☐ New services/ assistance ☐ Renewal of services/assistance ☐ Address change

3. How client applied: ☐ In Person ☐ By phone ☐ At Home ☐ Online/web service

4. Client: ☐ Submitted registration application ☐ Was sent form/application on ____/____/____ (date)

☐ Did not complete application/took form/application

SCMHC STAFF - PLEASE RETURN TO QI DEPARTMENT

Personal Safety Plan

Name: _____

Date: _____

You can document on this form suggested calming strategies IN ADVANCE of a crisis. You can list things that are helpful when you are under stress or are upset. You can also identify things that make you angry. Staff and residents receiving services can enter into a "partnership of safety" using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.

1. Calming Strategies:

It is helpful for us to be aware of things that help you feel better when you're having a hard time. Please indicate (5) activities that have worked for you, or that you believe would be the most helpful. If there are other things that work well for you that we didn't list, please add them in the box marked "Other". We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you're here.

☐ Listen to music	☐ Exercise
☐ Read a book	☐ Pace in the halls
☐ Wrapping in a blanket	☐ Have a hug with my consent
☐ Write in a journal	☐ Drink a beverage
☐ Watch TV	☐ Dark room (dimmed lights)
☐ Talk to staff	☐ Medication
☐ Talk with peers on the unit	☐ Read religious or spiritual material
☐ Call a friend or family member	☐ Write a letter
☐ Voluntary time in the quiet room/comfort room	☐ Hug a stuffed animal
☐ Take a shower	☐ Do artwork (painting, drawing)
☐ Go for a walk with staff	☐ Other? (Please list below)

2. What are some of the things that make you angry, very upset or cause you to go into crisis?

What are your "triggers"?

☐ Being touched	☐ Called names or made fun of
☐ Security in uniform	☐ Being forced to do something
☐ Yelling	☐ Physical force
☐ Loud Noise	☐ Being isolated
☐ Contact with person who is upsetting	☐ Some else lying about my behavior
☐ Being restrained	☐ Being threatened

3. Signals of Distress: Please describe your warning signals, for example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that most describe you when you're getting upset. This information will be helpful so that together we can create new ways of coping with anger and stress:

☐ Sweating	☐ Clenching teeth
☐ Crying	☐ Not taking care of self
☐ Breathing hard	☐ Running
☐ Yelling	☐ Clenching fists
☐ Hurting others	☐ Swearing
☐ Throwing Objects	☐ Not eating
☐ Pacing	☐ Being rude
☐ Injuring self: (Please be specific)	☐ Other? (Please list below)

Personal Safety Plan (page 2)

4. Preferences Regarding Gender and Others: Do you have any preferences or concerns regarding who serves you when you are upset or angry?

☐ Women staff ☐ Men staff ☐ No preference

☐ Language (specify): _____ ☐ Ethnicity (specify): _____

☐ Culture (specify): _____ ☐ Particular religion (specify): _____

5. Preferences Regarding Physical Contact:

We would like to know about your preferences regarding physical contact. For example, you may not like to be touched at all or you may find it helpful to have a hug or be touched *appropriately* when you are upset.

Do you find it helpful to be hugged or touched appropriately when you are upset? Yes ☐ No ☐

Comments: _____

6. Seclusion and Restraint:

This facility is trying to eliminate the use of seclusion and restraints; therefore, it would be helpful to know if you have ever been placed in a seclusion room or been restrained. This information will be used only for collecting data and for training purposes, not to predict any future behaviors.

Have you ever been placed in a seclusion room? ☐ Yes ☐ No

Have you ever been restrained? ☐ Yes ☐ No

7. In Extreme Emergencies:

In **extreme** emergencies, seclusion and restraint may be used as a last resort. Is there anything you find helpful in emergency situations that could prevent them from being used?

Alternative physical spaces such as ☐ Comfort Room ☐ Quiet Room

Other alternatives such as: ☐ Exercise ☐ Medication by mouth ☐ Emergency injection

☐ Other: _____

8. Medical Conditions:

Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during an emergency situation?

9. Helpful Medications:

We may be required to give medications if other measures do not help you to calm down. In this case, we would like to know what medications have been especially helpful to you? Please describe.

10. Not Helpful Medications:

Are there any medications that are not helpful? What and why?

Personal Safety Plan (page 3)

11. Trauma History:

Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with a counselor? Yes _____ No _____

Would you like more information on these issues in classes or support groups? Yes ____ No ____

12. Anything Else?

Is there anything else that would make your stay easier and more comfortable? For example, do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy. This form has been adapted from an original form created by the Massachusetts Department of Mental Health.

**South County Mental Health
Center, Inc.**

16158 South Military Trail
Delray Beach, FL 33484
(561) 495-0522 / 737-8400
Fax (561) 496-5064

Client Name _____

Chart #: _____

CONSENT FOR TREATMENT

I, _____, an applicant for the services of SCMHC voluntarily consent to treatment Or
I, _____, acting as representative or guardian, voluntarily grant permission to
SCMHC to render treatment, as deemed necessary, for the above named applicant.

CONSENT FOR TREATMENT

I hereby authorize SCMHC professional staff to administer treatment. I certify that I have been informed of the nature and the purpose of this treatment, alternative treatment modalities, approximate length of care, and I have been informed that this consent can be revoked orally or in writing prior to or during the treatment period. I understand that I am in a facility where medical, nursing, and behavioral health students train under the supervision of a professional staff.

CONSENT FOR MEDICATION

I understand that if medications are prescribed for me, the risks, benefits and possible side effects of such medications shall be explained to me. When medication is prescribed, I understand that I may request discontinuation of the medication at any time and discuss other treatment options. Medications may impair mental and physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery. The use of alcohol and/or other central nervous system depressant drugs are to be avoided due to the possible potential effects and hypotension. I understand that if I experience side effects that I should contact my case manager or doctor/ARNP immediately.

CONSENT FOR MEDICAL HEALTH EMERGENCY

In the event of an illness or medical emergency, I grant permission to the authorities of SCMHC to authorize medical services. These services may include Emergency Room or Inpatient/Outpatient care considered essential for my condition or illness.

In the event of an illness or medical emergency, I further authorize the physician, hospital or other professional providing the healthcare to release to SCMHC the medical records information specific to that episode of care.

COMMUNICABLE DISEASES

I understand that if a reportable communicable disease is diagnosed during the course of treatment, this diagnosis shall be reported to the State agencies along with patient identification in accordance with the Florida Statutes on communicable diseases and confidentiality.

I have read and fully understand the above Consent for Treatment. No guarantee or assurance has been made to me as to the results that may be obtained. I have read and fully understand the above, my questions have been answered and, to the best of my knowledge, the information supplied by me is correct and accurate.

CLIENT:

Printed Name

Signature

Date

PARENT/GUARDIAN:

Printed Name

Signature

Date

WITNESS:

Printed Name

Signature

Date



FINANCIALLY ASSISTED AGENCIES (FAA) NETWORK CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION IN CLIENT RECORD

AGENCY NAME: South County Mental Health Center, Inc.

This document is intended to provide you with information regarding our disclosure of confidential information contained in your client record.

The Financially Assisted Agencies (FAA) Network is a collaborative group of organizations that provide health and human services funded by Palm Beach County Board of County Commissioners.

The Financially Assisted Agencies (FAA) Network is committed to ensuring that the information maintained in your client records remains confidential, secure, and can be accessed only by individuals authorized to do so.

The Financially Assisted Agencies (FAA) Network uses a data collection and management system.

Your information will be maintained securely and is only shared with your consent, by signing this form.

The Financially Assisted Agencies (FAA) Network service providers will disclose to authorized staff the required data base demographic and Personal Health Information (PHI) about you. Disclosure is for the purpose of coordinating payment for care and to demonstrate that the quality of care provided is in accordance with accepted standards.

Information entered into the database will be maintained for an indefinite timeframe.

You have the right to request a copy of your file.

You have the right to refuse to answer any or all questions you consider sensitive.

You have the right to cancel this release of information for any future data input; however certain programs may have statutory mandated information requirements.

CLIENT NAME: _____

CLIENT NAME: _____

South County Mental Health Center, Inc (AGENCY NAME) is mandated to collect certain personal information that is entered and saved in a database system. Records are maintained in an encrypted database, on a secure server. Aggregate reports may be used for advocacy, and any client information used will be done so without revealing names or other information that would identify any specific client.

I _____ (Print Name) hereby provide my consent and authorization for _____ SCMHC (AGENCY NAME) to enter my client- specific service information in the encrypted database. This authorization allows the disclosure and sharing of the information entered into the database with the funder of the Financially Assisted Agency (FAA) Network.

Client Signature

Date

Witness Signature

Date

CLIENT NAME: _____

Acknowledgement of receipt of this form:

This is to acknowledge that I have reviewed this form, and have discussed it with the worker whose signature appears below. **I consent to entering into a client-provider relationship in order to receive needed services.** I have:

_____ Received a copy of this form
this form (Initial)

_____ Declined a copy of
(Initial)

Patient-Client / Representative / Guardian's Signature

Date

Patient- Client Representative / Guardian's Relationship

Agency Representative Signature

Date

Printed Name of Agency Representative

THE ORIGINAL SIGNED COPY OF THIS FORM IS FILED IN THE PATIENT/CLIENT'S RECORD

CLIENT NAME: _____

WITHDRAWAL OF CONSENT

I, _____ hereby WITHDRAW THIS CONSENT, effective
_____. Date of withdrawal

Client/Representative

Signature Date

Client/Representative Signature

Signature/Date

Witness

Client ID

Client Date of Birth

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
© 2008 The Research Foundation for Mental Hygiene, Inc.

RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.			
Suicidal and Self-Injury Behavior (Past week)		Clinical Status (Recent)	
☐ Actual suicide attempt	☐ Lifetime	☐ Hopelessness	
☐ Interrupted attempt	☐ Lifetime	☐ Helplessness*	
☐ Aborted attempt	☐ Lifetime	☐ Feeling Trapped*	
☐ Other preparatory acts to kill self	☐ Lifetime	☐ Major depressive episode	
☐ Self-injury behavior w/o suicide intent	☐ Lifetime	☐ Mixed affective episode	
Suicide Ideation (Most Severe in Past Week)		☐ Command hallucinations to hurt self	
☐ Wish to be dead		☐ Highly impulsive behavior	
☐ Suicidal thoughts		☐ Substance abuse or dependence	
☐ Suicidal thoughts with method (but without specific plan or intent to act)		☐ Agitation or severe anxiety	
☐ Suicidal intent (without specific plan)		☐ Perceived burden on family or others	
☐ Suicidal intent with specific plan		☐ Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)	
Activating Events (Recent)		☐ Homicidal ideation	
☐ Recent loss or other significant negative event		☐ Aggressive behavior towards others	
Describe:		☐ Method for suicide available (gun, pills, etc.)	
		☐ Refuses or feels unable to agree to safety plan	
☐ Pending incarceration or homelessness		☐ Sexual abuse (lifetime)	
☐ Current or pending isolation or feeling alone		☐ Family history of suicide (lifetime)	
Treatment History		Protective Factors (Recent)	
☐ Previous psychiatric diagnoses and treatments		☐ Identifies reasons for living	
☐ Hopeless or dissatisfied with treatment		☐ Responsibility to family or others; living with family	
☐ Noncompliant with treatment		☐ Supportive social network or family	
☐ Not receiving treatment		☐ Fear of death or dying due to pain and suffering	
Other Risk Factors		☐ Belief that suicide is immoral, high spirituality	
☐		☐ Engaged in work or school	
		☐ Engaged with Phone Worker *	
		Other Protective Factors	
		☐	
Describe any suicidal, self-injury or aggressive behavior (include dates):			

SUICIDAL IDEATION		Lifetime: Time He/She Felt Most Suicidal	Past 1 month
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.			
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. <i>Have you actually had any thoughts of killing yourself?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it." <i>Have you been thinking about how you might do this?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you had these thoughts and had some intention of acting on them?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i> If yes, describe:		Yes No ☐ ☐	Yes No ☐ ☐
INTENSITY OF IDEATION			
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.			
<u>Lifetime - Most Severe Ideation:</u> _____ Type # (1-5) Description of Ideation		Most Severe	Most Severe
<u>Recent - Most Severe Ideation:</u> _____ Type # (1-5) Description of Ideation			
Frequency <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day		_____	_____
Duration <i>When you have the thoughts how long do they last?</i> (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous		_____	_____
Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts		_____	_____
Deterrents <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply		_____	_____
Reasons for Ideation <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i> (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply		_____	_____

SUICIDAL BEHAVIOR (Check all that apply, so long as these are separate events; must ask about all types)		Lifetime		Past 3 months	
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, <i>as a result of act</i> . Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be any injury or harm , just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. Have you made a suicide attempt? Have you done anything to harm yourself? Have you done anything dangerous where you could have died? What did you do? Did you _____ as a way to end your life? Did you want to die (even a little) when you _____? Were you trying to end your life when you _____? Or Did you think it was possible you could have died from _____? Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-Injurious Behavior without suicidal intent) If yes, describe:		Yes ☐	No ☐	Yes ☐	No ☐
Has subject engaged in Non-Suicidal Self-Injurious Behavior?		Yes ☐	No ☐	Yes ☐	No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (<i>if not for that, actual attempt would have occurred</i>). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? If yes, describe:		Yes ☐	No ☐	Yes ☐	No ☐
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything? If yes, describe:		Yes ☐	No ☐	Yes ☐	No ☐
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? If yes, describe:		Yes ☐	No ☐	Yes ☐	No ☐
		Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:	
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death		Enter Code	Enter Code	Enter Code	
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care		Enter Code	Enter Code	Enter Code	

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Name: _____ Signature: _____ Date: _____

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? <u>Note:</u> By sexual contact we mean any contact between someone else and your private parts or between you and someone else's private parts	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	N/A	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	N/A	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? <u>Note:</u> Do not answer "yes" for any event you already reported in Questions 1-9	No Yes	N/A	N/A

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Name: _____ **Signature:** _____ **Date:** _____

In the past 12 months...			Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No	
2.	Do you abuse more than one drug at a time?	Yes	No	
3.	Are you always able to stop using drugs when you want to?	Yes	No	
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No	
5.	Do you ever feel bad or guilty about your drug use?	Yes	No	
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No	
7.	Have you neglected your family because of your use of drugs?	Yes	No	
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No	
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No	
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No	
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.				Score:

Interpretation of Score		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Generalized Anxiety Disorder (GAD-7 Anxiety) Scale

Name: _____ Signature: _____ Date: _____

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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

☐
☐
☐
☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved.
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Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Name: _____ Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ-9)

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?	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

Add columns 0 + _____ + _____ + _____
=Total Score: _____

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

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
☐