Children's Residential Treatment Center
Medical Intake Information

The following is required at/by intake:

❑ Copy of Current Insurance Cards (Medical, Dental, or Medical Assistance)

❑ Proof of Physical within 6 months of admission date (*see Admission Medical Information Packet)*

❑ At least 3 days of all medications. This is preferred; however, we will also accept 30 days of medications in the bottles. It is not necessary to refill prescriptions in order to have 30 days of medications. This includes all pills, inhalers, topical creams, or epi-pens.

❑ ALL medications that will be administered must have a prescription. This includes any vitamins or supplements. Please have your primary care physician write prescriptions for these medications.

❑ Any special doctor's orders. We will need to have a doctor's order if your child has any special medical need. For example, doctor's orders are necessary if your child is vegetarian, lactose intolerant, has any particular food allergies or restrictions, has any medical restrictions pertaining to exercise or physical activity, or mobility issues.

Health History Form

Resident's Name: ________________________________ D.O.B.: ________________

Primary Care Physician's Name and Address*: __________________________________

Date of last exam: ___/___/___ __________________________________

Immunizations are up to date: ❑ Yes ❑No __________________________________

Does your child have any allergies (including dietary) or other dietary restrictions?

❑ Yes ❑No Please describe allergies or dietary restrictions: ___________________

____

****PLEASE INCLUDE COPY OF IMMUNIZATIONS****

*I would prefer to continue with my primary health facility and I will take responsibility for scheduling appointments and transporting my child as needed. ❑ Yes ❑No

Note: For any appointments made by parents/guardians, please notify nursing staff so that it can be put on the CRTC schedule.

Dentist Name and Address: __________________________________

Date of last exam: ___/___/___ __________________________________

____

Optometrist Name and Address: __________________________________

Date of last exam: ___/___/___ __________________________________

____

Current Medications:

Medication Name:	Dosage/ RX Number::
Pharmacy Name:	Pharmacy Phone/Fax:
Prescribing Doctor:	Doctor Phone/Fax:
Doctor's Clinic:	Doctor Fax:

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Medication Name:	Dosage/ RX Number::
Pharmacy Name:	Pharmacy Phone/Fax:
Prescribing Doctor:	Doctor Phone/Fax:
Doctor's Clinic:	Doctor Fax:

Previous Medications that have been discontinued:

Name:	Dosage:
Name:	Dosage:
Name:	Dosage:

Below is a list of health conditions. Please review the conditions and indicate whether or not your child has experienced any of the following:

Condition:	Yes	No
Allergies		
Asthma		
Broken Bones		
Closed Head Injury		
Diabetes		
Headaches		
Hernia		
High Blood Pressure		
Low Blood Pressure		
Seizure		
Skin Conditions		
Stomach Ulcer		
Other:		

If you answered yes to any of the conditions listed above please give a brief description:

___

___

___

Does your child eat three meals per day? ❑ Yes ❑No

Has your child restricted her intake? ❑ Yes ❑No Does s/he purge? ❑ Yes ❑No

Explain:___

___

Does your child have difficulty sleeping? ❑ Yes ❑No

Does she use a sleep aid? ❑ Yes ❑No

Explain:___

___

Does your child participate in sports? ❑ Yes ❑No

Is your child engaged in physical activity daily? ❑ Yes ❑No

What activity and what time intervals? ___

___

Has your child used tobacco? ❑ Yes ❑No Last use: ___/___/___

Has your child used alcohol? ❑ Yes ❑No Last use: ___/___/___

Has your child used illegal substances? ❑ Yes ❑No Last use: ___/___/___

Has your child abused prescription drugs? ❑ Yes ❑No Last use: ___/___/___

Please list and explain any hospitalizations your child has had:

____
____
____
____
____
____

FAMILY MENTAL HEALTH HISTORY

Is there a history of mental health problems in the family? ❑ Yes ❑No
Who:____

What was the problem? ____

Was medication helpful? ❑ Yes ❑No
If yes, please list the medications that were helpful: ______________________

____

____

Who:____

What was the problem? ____

Was medication helpful? ❑ Yes ❑No
If yes, please list the medications that were helpful: ______________________

____

____

Who:____

What was the problem? ____

Was medication helpful? ❑ Yes ❑No
If yes, please list the medications that were helpful: ______________________

____

____

Children's Residential Treatment Center
Medication Verification Form

CRTC is required to obtain verification of all incoming medications. Please complete this form and provide all the required information prior to intake.

Resident Name: ______________________________ Date of Birth: ________________

I authorize the disclosure of records/information about my child between:

Attention: Nursing Department, Jack Stark, RN	Clinic/Hospital Name:
Volunteers of America MN – Children's Residential Treatment Center	Address:
143 East 19th Street Minneapolis, MN 55403	City, State, Zip
Phone: 612-870-4300	Phone
Fax: 888-925-5129	Fax

Medication/dosage:		Medication/dosage:	
Administration Instructions:		Administration Instructions:	
Symptoms Targeted:		Symptoms Targeted:	

Medication/dosage:		Medication/dosage:	
Administration Instructions:		Administration Instructions:	
Symptoms Targeted:		Symptoms Targeted:	

Medication/dosage:		Medication/dosage:	
Administration Instructions:		Administration Instructions:	
Symptoms Targeted:		Symptoms Targeted:	

This form is valid for **1 year** unless parent/guardian submits in writing a request for cancellation of this release of information.

MD/CNP Signature Date Witness Signature Date

Client Signature Date Parent/Guardian Date

CRTC Nursing Information

Resident Name: ______________________________ Date of Birth: _______________

Date of Admission: ____________________________ Unit: _______________________

Please acknowledge by initialing each paragraph:

_______ **Psychiatric Evaluation:**
When a resident is admitted to CRTC they will meet with Dr. David Cline, MD and/or Jack Stark, RN shortly after intake and on a scheduled basis for psychiatric care.

_______ **Appointments:**
The nurse is responsible for scheduling medical appointments in which the counseling staff will accompany the resident to the appointment. Appointments made with resident's primary physician/dentist should be communicated to the nurse. These appointments, which are made with a primary care physician, will require parent/guardian transport. The nurse will notify parents/guardian of appointments as needed.

_______ **Emergency Medical Care:**
In case of your child needing emergency medical attention, CRTC employees will ensure you child is brought to the emergency department. Depending on the situation and safety of the resident, this will either happen by CRTC calling for an ambulance, or will transport the resident. A CRTC employee will stay with the resident until either a parent/guardian relieves the employee or the resident is admitted. It is the expectation that upon notification that your child is going to the emergency room, you make arrangements to meet the child as soon as possible. This is necessary so that CRTC employees are able to return to CRTC as soon as possible, and continue providing supervision and milieu support to the other CRTC residents.

_______ **Release of Sexual Health and Substance Use Information (Protected):**
I understand that my child has the right to not disclose with their parent/guardian information regarding sexual health concerns or substance use history as this is protected health information. In order for CRTC to disclose information regarding sexual health or substance use, my child must sign a release of information. Without a signed release of information, CRTC is only able to this protected information when failure to do so would put the resident at significant risk of harm.

_______ **Medication Consent Information:**
For any new psychotropic medications the nurse will contact parents/guardian for consent and will provide information on the medication. Parent/guardians will receive a written consent form, which will require a signature.

_______ **Pharmacy Information:**
Prescriptions are filled by Bloomington Drug Pharmacy. Prescription medications for residents are prescribed by our psychiatrist and dispensed under the direction and supervision of our Registered Nurse. The financially responsible party is liable for all insurance co-payments and deductibles owed to the pharmacy. Over the counter medications are dispensed from CRTC stock via standing medication orders.

_______ **Billing Information:**
Per diem cost of care is billed to the referring county or participant's insurance agency. Volunteers of America's Mental Health Clinics services (psychiatric assessment and medication management, psychological assessment and testing) are also billed to the participant's health care plan. Parent/guardians are responsible for all charges incurred, including deductibles, co-insurance and co-payments. Please contact your insurance company with questions about coverage.

****ALL PRESCRIPTION AND OTC MEDICATIONS, INCLUDING INHALERS, EPI-PENS, OR VITAMINS/SUPPLEMENTS, MUST BE BROUGHT TO THE INTAKE MEETING****

_________________________________ _________________________
Parent/Guardian Signature Date

_________________________________ _________________________
Parent/Guardian Signature Date

_________________________________ _________________________
Witness Signature Date

Consent for Care and Treatment

_______ I hereby authorize Volunteers of America Minnesota – Children's Residential Treatment Center to provide 24-hour care and mental health treatment. This may include the performance of diagnostic tests, assessments, procedures and treatments. Trained staff will administer medications deemed appropriate by the physician or other personnel involved in my care. I understand that the consulting psychiatrist is not an employee or agent of this health care facility, but is an independent contractor who has been granted privileges to treat clients in this health care facility. This consent for treatment includes the services of this practitioner as well.

_______ I further understand and acknowledge that the practice of medicine and psychology is not an exact science. I acknowledge that no guarantees have been made to me about the results of the examination and/or treatment to be provided in this health care facility.

_______ If psychiatric medications are part of the treatment plan, I understand and agree that my permission must be given to start or change psychotropic medication. However, for adjustments of or discontinuation of psychotropic medication, my consent is not required. I also give permission to have my child complete any educational and/or psychological testing deemed appropriate by the treatment staff.

_______ I also authorize Children's Residential Treatment Center staff to arrange for the provision of any routine or emergency services of medical or dental care. If, in the opinion of the attending duly qualified physician/provide, said services are deemed necessary or advisable, and these may be performed on my child/ward while a resident at Children's Residential Treatment Center. I understand that I will be kept fully informed of any medical or dental problems or conditions my child may have.

___________________________________ ___________________________
Parent/Guardian Signature Date

___________________________________ ___________________________
Parent/Guardian Signature Date

___________________________________ ___________________________
Witness Signature Date

Please complete this form to begin receiving services from Bloomington Drug Pharmacy. This form can be returned to the pharmacy or faxed to 952-884-6366. Please contact us with any questions about this process of completing this form.

Resident's Name: ____ Date of Birth:________

Please choose one of the following options:

❑ House Charge

Each month you will receive a bill from Bloomington Drug. This bill is to be paid in full by the end of each month.

Billable Party Name: ____

Billing Address: ____

Phone Number: ____

❑ Credit Card

Each month the following credit card will be charged by Bloomington Drug during the first week for services received in the previous month.

Credit Card Holder's Name: ____

Credit Card Type/Number: ____

Expiration Date: _______________________ Security Code: ____________

Phone Number: ___________________________________

I acknowledge that I have provided current insurance information to Bloomington Drug and I understand that I am responsible for all co-pays with my medication(s). I agree to pay Bloomington Drug any remaining balance of my account if I were to move out of this facility.

Signature: ____ Date:______________

If applicable, please include copies of the front page and the signature page of your Power of Attorney Paperwork.

509 West 98th Street, Bloomington MN 55420
phone: 952-884-7528 fax: 952-884-6366
www.bloomingtondrug.com

Authorization for Release of Information

By completing and signing this form you are authorizing Park Nicollet Health Services to release the information marked below. Park Nicollet Health Services includes Park Nicollet Methodist Hospital and Park Nicollet Clinic.

118534AUTHR

Patient

Patient name	Previous last name (if any)
Street address	Date of birth
City / State / ZIP code	Phone #

Information to be released *(select any)*

Medical records
- ☒ Clinic visit notes ☐ Radiology reports ☐ HIV or AIDS records ☐ Other (specify) (e.g., non-Park Nicollet records) ______
- ☒ Mental health records ☒ Lab reports ☐ Pathology reports
- ☒ Chemical dependency ☐ Radiation therapy ☒ Hospital

Records concerning/Dates requested/Special Instructions

Radiology image release *(In most cases you will receive your images in digital format (CD))*
- ☒ General X-rays Date(s) ______ ☐ Nuclear medicine Date(s) ______
- ☐ MRI Date(s) ______ ☐ Pet scan Date(s) ______
- ☐ CT Date(s) ______ ☐ Include radiology report(s)
- ☐ Ultrasound Date(s) ______

Mammography imaging release
- ☐ 30 day loan ☐ Permanent transfer ☐ Include radiology report(s)

Pathology
- ☐ Pathology slides

Purpose for release
- ☐ Continuation of care—Radiology ☒ Insurance* ☐ Legal*
- ☐ Continuation of care—Medical Records *(6 visits or 6 months)* ☐ Out of town move *(send 2 yrs)* ☒ Other Out of home placement
- ☐ Disability
- ☒ Insurance change ☒ Personal*

* *Pre-pay charges apply for radiology images*

To whom should the information be released?

To whom should the information be released? *(e.g., provider, insurance company, attorney, patient)* —**This section must be completed**

Radiology Image Release: Pre-pay charges apply for images released to patient without provider/facility information

Facility/Provider/Insurance company/Attorney/Patient name	Phone #
Children's Residential Treatment Center	612.870.4300

Street address	City	State	ZIP code
143 E. 19th Street	Minneapolis	MN	55404

Method of delivery

Select one option for each type of record, if applicable.
Picture ID is required when picking up records. Written permission is required if someone other than patient is picking up information.

Medical records
- ☒ On paper ▶ ☐ Mail before (appointment date) ____ /____ /____ ☐ I will pick up on (date) ____ /____ /____
- ☐ Via secure email *(requires internet access)* ▶ Patient email address ______

Billing records
- Statement date(s) ____ /____ /____ – ____ /____ /____ ▶ ☐ On paper ☐ On CD *(requires PDF Reader software)*
- ☐ Send via US Mail ☐ I will pick up on (date) ____ /____ /____

Authorization and Revocation

I authorize Park Nicollet Health Services to release the information marked above. I understand I need not sign this form in order to assure treatment or payment. I understand that upon release, this health information is no longer protected by Park Nicollet Health Services and has the potential to be re-disclosed by the recipient. **I understand there may be a charge for my records per Minnesota Statute 144.292.**

Revocation: I understand that this authorization will be valid for 12 months from the date signed to release any records created up to the date of signature. Any records created after the date of this authorization will require a new authorization. I understand that I may cancel this authorization, by sending a written request for cancellation to Park Nicollet Release of Information, and that the cancellation will take effect when Park Nicollet Release of Information receives my written notice.

Patient signature	Date
If other than patient, state relationship and reason patient unable to sign	

Mailing instructions

Mail completed authorization to:	For radiology images *only*, mail authorization to:	Emergent after hours (5 pm - 8 am) requests *(health care facilities only)*:
Release of Information Park Nicollet Health Services 3800 Park Nicollet Blvd., St. Louis Park, MN 55416 952-993-7600 tel / 952-993-1811 fax	Central Film Library Park Nicollet Imaging Services 3930 Louisiana Circle, St. Louis Park, MN 55426 952-993-5427 tel / 952-993-1718 fax	Fax completed form to 952-993-6496