**Patient's Name:**__________________________________

## Out-of-State Patient Referral Checklist

Client's Name ______________________________________

Facility ___________________________________________

Contact person _____________________________

Phone: ____________________________________

Fax: ______________________________________

Email: ____________________________________

**Documentation:**

CRSA: ____________________________________

CON: _____________________________________

ITR: ______________________________________

CONSENTS: ________________________________

VALUE OPTIONS: ____________________________

BIRTH CERTFICATE: __________________________

SOCIAL SECURITY: ___________________________

IMMUNIZATION: _____________________________

MEDICAID CARD: ____________________________

**Patient's Name:**___________________________________

School Contacts:

SCHOOLDISTRICT: ___________________________________

CONTACT INFO: _____________________________________

DSS GUARDIAN: ___________________________________________

CONTACT#: ___________________________________________

***ADMISSION PACKAGE***

**From: Admissions Department**

To: ______________________________________________________________

Regarding: ______________________________________________________________

Before your patient is accepted for admission to the PRTF please follow these steps:

(1) Complete and return as soon a possible the enclosed forms (consents and chrono-bio). This will place your patient on the waiting list.
(2) If and when you are notified of admission, we must have the following, which you may bring at time of admission:
   a) Current Medicaid card (if applicable)
   b) Current Referral Form/Authorization for Services
   c) Current Certification of Need form for In Psychiatric Services for Children Under Age 21
   d) Copy of current physical examination indicating the following tests and results:
      1) Tuberculosis
      2) HIV
      3) Hepatitis B
   e) Copy of all legal documents (Court order, custody order, probation terms, treatment furlough from DJJ, etc.)
   f) Immunization records
   g) Copy of birth certificate
   h) Copy of social security card
   i) Current Individualized Education Plan (IEP)
   j) Copy of Person Center Plan (PCP)

***<u>PLEASE NOTE:</u>*** Case managers should not give their patients any information concerning possible length of stay at the PRTF. Our experience has been such that if a patient is "armed" with a possible date of discharge, no matter how vague, he/he/she generally fixates on this date and resorts to manipulation of both the case manager and PRTF staff.

Case managers should establish a mutually agreed upon routine for visits and telephone calls to check on their patient's condition and progress. Also, if the patient is allowed family contact, we will need that information. Lastly, please inform us of any impairment or contraindication of the type of physical restraint or isolation, if the need presents itself.

**Patient's Name:**__________________________________

Please be advised that the PRTF does not accept any liability for personal property of the Patients. The patients trade these items and such activities are impossible to regulate. Moreover, there are insufficient storage facilities at the PRTF.

***The following personal items are needed:***

| ITEMS | NEEDED |
|---|---|
| Sneakers | 2 pair |
| Socks | 7 pair |
| Underwear | 7 pair |
| Shirts | 7 pair |
| Pants | 7 pair |

***Please DO NOT BRING THE FOLLOWING:***
**(*In general nothing that can be converted into a weapon)***

| | | |
|---|---|---|
| *Knife* | *Radio/TV* | *Pens or Pencils* |
| *Alcohol-based items* | *Toiletries* | *Jewelry (earrings, chains, etc)* |
| *Cigarettes or Cigarette Lighters* | *Toothbrush* | *Cassette/CD Player or CDS and Tapes* |
| *Matches* | *Picture Frames* | *Whiteout* |
| *Glass Items* | *Magazines* | *Needles* |
| *Nail Clippers* | *Money* | |

**PRTF will not be responsible for clothing items above the stated limits listed in personal items columns.**

## PATIENT INFORMATION

***Patient Categories***:
All new patients are admitted to the Intake Unit at the PRTF. The Intake Unit prepares SED children to be assessed, orientated, and introduced into the PRTF Program and provides **Security** and **Safety**, to deter their tendency for acting out.

***Patient Activities:***
Patients are expected to attend and participate fully in all activities and therapeutic offerings suggested by the PRTF therapeutic staff. Expectations for each activity will be explained by staff responsible for patient at that time. A list of explanations for each offered activity will be supplied to any parent or guardian requesting such.

***Behavior Management Program:***

Patients are required to complete the Introduction Unit designed to deal with each patient's own particular behavior problems and assess the needs of each patient. After satisfactory completion of the Introduction Unit patient will start the advanced unit of the PRTF Program. Each unit is designed to help the patient reach her goals by using:

A. Psychiatric Evaluations
B. Psychological Evaluations
C. Intake Evaluations
D. Behavior Management
E. Individual Therapy
F. Group Therapy
G. Family Therapy
H. Crisis Management
I. Rehabilitative Psychosocial Therapy
J. Restorative Independent Living Skills
K. Medical Services

***Patient Expectations:***

1. Patients are expected to respond to all staff directives in a prompt and respectful manner.
2. Patients are expected to address their peers in a cordial and polite manner.
3. Patients are expected to refrain from using physical or verbal intimidation toward staff and peers.
4. Patients are expected to be on time for each assigned task and to complete each task in the allotted time.
5. Patients are expected to be on time for all meals and to remain seated until all Patients are excused.
6. Patients are expected to observe all the rules of the PRTF program and to comply without hesitation.

***Case Managers and Parents/Caregivers***:

As part of the patient's support system that assists in successful treatment, it is requested that a mutually agreed upon routine for visits and telephone calls is established. It is expected and encouraged that visits and telephone calls occur to check on their patient's condition and progress. Also, if patient is not allowed family contact we will need that information.

*****Please bring only prescribed Medications currently being taken***

## INFORMATION REQUESTED FOR

## INTERDISCIPLINARY ADMISSIONS TEAM

**To: All Referring Agencies and Case Managers:**

**Re: REQUIRED DOCUMENTS FOR EACH REFERRAL**

**Purpose:** ***For the PRTF Interdisciplinary Admissions Team***

***PRTF Definition:***
A Psychiatric Residential Treatment Facility (PRTF) Services are defined as highly structured therapeutic environments providing for the diagnosis and treatment of severely emotionally disturbed and/or children challenged with mental illness. PRTFs are for children under the age of 21 who require less than acute in care but who need a structured environment with intensive treatment. PRTFs have intensive staff supervision and programs for emotionally disturbed and/or youth challenged with mental illness.

These youth are not able to live in a less restrictive environment due to the intensity and/or the severity of their current emotional problems behavioral disorders, and/or acting-out behaviors. The goals of the PRTF is to alleviate immediate emotional problems or immediate psychiatric symptoms; evaluate and provide the treatment needs of the child or adolescent; and restore the patient to a stable functioning level leading to his/her return home, or to a less restrictive environment.

In order to determine the appropriateness for a referral admission to the PRTF, the Interdisciplinary Admissions Team requests the following documents:

1. A fully completed Children's Services Application and description of family involvement.
2. A copy of the most recent discharge summary
3. A copy of the most recent treatment plan (including a brief summary of progress on each goal).
4. Copies of any current court orders pertaining to the patient being referred,
5. Copies of any records of medical or psychiatric treatment, psychological testing, and immunization records.

In addition to the above requested documentation, a case manager or agency representative with knowledge of the referred patient is requested to appear at the Interdisciplinary Admission Team's meeting to consider the application or to be able to provide needed psychosocial and background information on the patient to assist in the admissions process prior to the meeting of the admissions team.

## ADMISSIONS CRITERIA

There are two types of Medicaid admissions to PRTFs: ***urgent admissions***, and children and adolescents who become Medicaid eligible after their admission (***post-admission eligibility***). Each admission type requires the approval and requirements of a particular team type. ***Urgent admissions*** require the approval of an independent team. ***Post-Admissions*** eligibility requires the approval of the facility's interdisciplinary team.

***Urgent Admission:*** *An urgent admission is one in which the patient meets the CON criteria but is not presenting immediate danger that would cause death, serious impairment to the health of the patient, or bodily*

*harm to another person by the patient. An* *independent team* *meeting the requirements for CON teams will complete the CON form for urgent admissions to the PRTF.*

***Independent Team:*** *An independent review team is a team that is "independent" of the facility. No member may have a financial, employment, or consultant relationship with the admitting facility. This type team must include (1) a physician (referring, attending, or family physician) who has competence in diagnosis and treatment of mental illness, and has knowledge of the patient's situation, and (2) one or more professionals who are involved in the recommendation for placement of the patient in the PRTF***.**

***Post Admission Eligibility:*** *The facility's* *interdisciplinary team* *will complete the CON form for Patients who become Medicaid eligible after their admission to the PRTF (post-admission eligibility). The completed CON form must cover any period before the Medicaid application and relevant claims.*

***Interdisciplinary Team:*** *The facility-based interdisciplinary team shall be responsible for post-admission eligibility and for the development and review of the plan of care. The team shall be composed of physicians and other personnel who are employed by the facility, or provide services to Patients in the facility.*

**PRTF Admission Criteria:**

1. ***Impaired Safety ( Patient poses a threat to the safety of self or others due to behaviors related to mental illness or emotional disturbance***
2. ***Impaired Thought Process (severity and persistence of the patient's emotional/behavioral problem and need structured environment with intensive treatment)***
3. ***Alcohol and Drug Detoxification or emotional problems related to a substance abuse history with high risk for relapse***
4. ***Less Restrictive Environment (Indicated by progress in psychiatric acute care hospital_ __***

***Other Criteria:***
***EDUCATION***

***Our PRTF's are Licensed by SC Department of Health and Environmental Control (DHEC) and we are enrolled in both NC and SC Medicaid. We are not providers of educational services. We do facilitate contacts between educational providers. In order to facilitate our out-of-state patients, we require that the parents/guardians/custodians of out-of-state patients provide us with proof that contact has been made with the school districts of the State and County of their residency, and that they have been notified that this patient will be in treatment in the State of South Carolina.***

## SPECIAL NOTICE

**Patient's Name: ____________________________________________**

The PRTF is a secure psychiatric residential treatment facility. The residents have a history of severe emotional disturbance and behavioral problems with a potentially violent and aggressive propensity in their background. Therefore, it is critical that everyone involved in the care of this child/adolescent understand the importance of doing everything possible to ensure the safety of all Patients and staff. Therefore, please read the following statement carefully, sign and date in the appropriate place indicating your agreement, and return this form along with all other signed forms before admission date.

1. The PRTF considers the safety of each patient and each staff person to be a priority in providing a safe, secure therapeutic environment necessary for the recovery of severely emotionally disturbed females. Therefore, primary and secondary case managers, parents, and custodial agencies should all be aware of our procedures and policies concerning the search and examination of all packages, boxes, luggage, and book bags before they are allowed entry to the PRTF. This search and examination is necessary due to the possibility of inappropriate information to be conveyed by written communication, all correspondence is reviewed by the PRTF staff.
2. The PRTF reserves the right to ask for proper identification of all persons entering our facility. Any packages, boxes, envelopes, parcels, and containers are subject to examination and search for contraband before being given to the patient to which they were addressed.
3. PRTF in addition has a policy to search the body of Patients. This search is necessary as the Patients are in the last stages of the program exposed to a variety of non-secure environments; they are searched upon their return. After home visits and personal contacts with family, they will be searched. The danger of harmful items – contraband and weapons – must be identified. This policy will be made available to you upon request.

***No disrespect of the rights and privileges of any individual are intended,***
***but our goal is for no one to be harmed.***

| | |
|---|---|
| ________________________ Case Manager | ____________ Date |
| ________________________ Parent / Guardian | ____________ Date |
| ________________________ Patient | ____________ Date |

**Patient's Name:_________________________________**

## CONSENT AND CONDITIONS FOR ADMISSION

**Notice: This document provides an assignment of your right to collect or receive any reimbursement for services rendered by the PRTF or any other entity to whom/which your child /you may be referred**.

I, _______________, wish for my child, ________________, to be admitted to the Psychiatric Residential Treatment Facility (PRTF). He/she will be treated by psychologically trained persons, behavior guides, and medical professionals at the PRTF. While he/she is in the PRTF's care, I authorize and permit the staff to treat him/her in ways they believe will be of benefit to him/her. I understand that this may include medical and psychological tests, examinations, therapeutic, psychological, psychiatric treatment, medication, or other activities, restriction from leaving the facility, and participation in educational pursuits, with which we will cooperate. A psychiatrist will perform tests and prescribe medication. We understand that medical doctors, nurses, and other persons under their direction will perform physical examinations and other medical invasive tests, and they may recommend and provide treatment, with which we will cooperate. We understand that the program may also include in the therapeutic regime **restraint, including personal, mechanical, chemical, and seclusion, but restraints are only utilized in case self-harm, or harm to others.** Medication is supplied for therapeutic benefit. No guarantees have been made to me regarding the outcome of this case.

We understand that the Psychiatrist and/or other medical staff as well as the Facility Director or their designee may authorize a search of my room, belongings, or person from time to time and with or without my notice to ensure articles such as chemical substances or items they consider dangerous are neither in my possession, available to me, nor available to others. We give our consent to such inspections for contraband and to their need to remove any such item from my possession. I unconditionally waive any and all claims which I may have as a result and release PRTF and its staff from any and all liability which may arise as a result thereof.

We hereby give our consent and authorization to release any part or all of my chart or summary of charted activity to any case manager or sponsoring agency involved in my on-going care or supervision and education. I consent that any such material may be sent to any medical or mental health educational or vocational service to which I am referred during my tenure at PRTF. I authorize the exchange of information with these services. This authorization will terminate upon one year following the discharge from the program. I also reserve the right to remove this authorization at any time upon the delivery of a written notice. This will occur within six (6) days of the delivery of the written notice.

Initials: ___________

**Patient's Name:**________________________________

I/We agree to cooperate with any necessary activity to collect payment or to pay for the services rendered by the PRTF or any entity or person to whom my child/self is referred by it or its employees. This may include application or reapplication for Medicaid, health insurance, and/or payment of any deductible to the PRTF or any other service provider.

I/We further assign and transfer any rights of collection for services to the PRTF. We will use only their address for billing and collections of funds for the services rendered. The address is: P.O. Box 968, Travelers Rest, South Carolina, 29690.

I/We understand and agree to the condition that I am prohibited from bringing any unauthorized medications or contraband into the PRTF. I/We agree to cooperate with the staff and abide by all rules and regulations of the PRTF. I acknowledge that my treatment is of no value without my/our cooperation.

We hereby authorize any medical provider, whether doctor or hospital, parent, state agency of the State of South Carolina or any other state of the United States of America, prison, employer, guardian, Protection and Advocacy for the Handicapped or similar entity, court and/or attorney at law, state or federal registry of crimes or misconduct to provide copies of any medical history, immunization records, x-ray and other medical test data, educational data or tests, psychological tests, chrono-biological information, conviction data, and/ or records necessary for the patient's treatment.

I HAVE READ, UNDERSTAND, AND AGREE TO THE CONDITIONS OF ADMISSION, I GIVE MY CONSENT FOR TREATMENT. **I have been provided a copy of all documents relating to the admission.**

| | |
|---|---|
| ________________________________ | ________________ |
| Case Manager | Date |
| ________________________________ | ________________ |
| Parent / Guardian | Date |
| ________________________________ | ________________ |
| Patient | Date |
| ________________________________ | ________________ |

## CONSENT FOR PARTICIPATION IN REHABILITATIVE SERVICES ACTIVITIES

**Patient's Name:** ______________________________________________

I, hereby, give consent and permission for my child/adolescent to attend and participate in (including hands-on activities) designed to develop and practice adult-like environmental opportunities which include active sports, and restorative living skills in accordance with the PRTF's Policies and Procedures.

| ______________________________ | ______________ |
|---|---|
| Case Manager | Date |
| Parent / Guardian | Date |
| Patient | Date |

## CONSENT TO TREATMENT AND TRANSPORT

**Patient's Name:** ______________________________________________

In the event that an emergency and/or routine medical treatment arises involving my child and any medical treatment is required, I give my consent to the PRTF to provide onsite (or to transport my child to a hospital or other medical center) administer medication, provide emergency medical services, routine or necessary medical services, and surgical services. I further agree that PRTF is authorized on my behalf to consent to any such medical or surgical services. Also, I give my consent to the receiving hospital or other facility, and any other medical provider or doctor to admit, provide, and deliver emergency medical treatment, routine or necessary medical services, and surgical services to my child only as deemed necessary. I understand that this will only be done if in the judgment of authorized medical personnel it is necessary for the well-being of my child.

| ______________________________ | ______________ |
|---|---|
| Case Manager | Date |
| Parent / Guardian | Date |
| Patient | Date |

## CONSENT TO LEAVE GROUNDS

**Patient's Name:** ______________________________________________

I hereby give my consent to attend therapeutic activities off the PRTF property. I understand that there exists a possibility that persons not affiliated with the PRTF may be encountered on these outings and agree that my

child's attendance at these activities will not be a violation of my child's rights or privacy.

| ______________________________ | ______________ |
|---|---|
| Case Manager | Date |
| ______________________________ | ______________ |
| Parent / Guardian | Date |
| ______________________________ | ______________ |
| Patient | Date |

**CONSENT FOR ADULT-LIKE ACTIVITIES**

**Patient's Name:** _____________________________________________

I hereby give consent and permission for my youth to use electrical appliances in accordance with PRTF's policies and procedures and absolve the PRTF from any and all responsibility from burns, injuries, or property damage which may result from or because of such appliances. I hereby give my consent for my youth to engage in adult-like activities (examples are vocational training; driver license, checking account).

| ______________________________ | ______________ |
|---|---|
| Case Manager | Date |
| ______________________________ | ______________ |
| Parent / Guardian | Date |
| ______________________________ | ______________ |
| Patient | Date |

**Patient's Name:**________________________________

## CONSENT FOR TIME OUT & RESTRAINT

I/We have been informed that personal restraint, mechanical, and seclusion may be placed or applied for my child's personal protection, other Patients, and the staff. I hereby agree that Excalibur may use such methods upon my child and instruct the PRFT and its staff judiciously to place or apply temporary restrictions when the patient is clearly demonstrating behavior that harms or threatens to harm other Patients, staff, or self.

**Personal Restraint:** The application of physical force by one or more PRFT staff that reduces or restricts an individual's freedom of movement. (This does not include the temporary physical holding of an individual to help her participate in activities of daily living.)

**Mechanical Restraint:** The use of any device, article, or garment attached or adjacent to an individual's body that restricts an individual's freedom of movement. (Mechanical restraint does not include items such as orthopedically prescribed devices, surgical dressings, protective helmets, or any methods of holding for the purpose of conducting physical examinations or tests. It also does not include devices that protect the individual from falling out of bed or permit the individual to participate in activities of daily living without risk of harm to her/him.)

**Chemical Restraint:** The use of medication to manage a patient's behavior in a way that reduces the safety risk to the patient or others; has the temporary effect of restricting the patient's freedom of movement; and is not a standard treatment for the patient's medical or psychiatric condition. All chemical restraints are IM and done by the nurse on-call.

**Seclusion:** The confinement of an individual in any room and physically preventing the individual from leaving. Seclusion does not include time-outs. A room used for seclusion must allow staff full view of the resident in all areas of the room and be free of potentially hazardous.

**Time-out** is the withdrawal of reinforcement of inappropriate behavior, during which an individual is not provided the opportunity to participate in the current routine and activity until he/she is less agitated. Time-out is used to teach individuals to calm themselves and is not a punishment. The duration of time-out is only limited to the amount of time it takes the individual to calm himself.

I/We have been involved in and initial assessment to obtain information about my child or youth that may help to minimize the use of restraint or seclusion. The initial assessment has identified: the individual's past history of violence, events that may trigger aggressive outbursts, techniques to regain control, the individual's need for tools to manage her own aggressive behavior, preexisting medical conditions or physical disabilities that place the individual at greater risk of harm, and any history of physical or sexual abuse that places the individual at higher psychological risk if he/she is restrained or secluded.

Initials: ___________

**Patient's Name:**________________________________

## CONSENT FOR TIME OUT & RESTRAINT (con't)

I/We have been provided a copy of the Behavior Management Procedure. I further understand that I/we may follow the grievance procedure to report a concern about seclusion or restraint. I have been given the opportunity to view the seclusion rooms.

All communication has taken place in a language that I/we understand.

________________________________________ ____________________
Case Manager Date

________________________________________ ____________________
Parent / Guardian Date

________________________________________ ____________________
Patient Date

________________________________________

**Patient's Name:_________________________________**

# PHI / HIPAA NOTICE

**This notice describes how treatment information about you may be used and disclosed and how you may get access to this information. Please review it carefully.**

Under HIPAA privacy regulations, the program operated by Excalibur Youth Services, LLC., Psychiatric Residential Treatment Facility (PRTF) is required by federal law to maintain the privacy of your protected health information (PHI). Please understand that this facility may use your PHI in rendering treatment to you. Also, we are permitted to disclose your PHI for treatment purposes to third parties and for billing purposes. Your PHI will be disclosed to the Secretary of Health and Human Services. In addition, your PHI will be used in accordance with the specific requirements of the HIPAA regulations without disclosure to you or without your permission in the following instances:

The disclosure is required by law.
The disclosure is required for public health reasons.
The disclosure is required about victims of abuse, neglect, or domestic violence.
The disclosure is required by health oversight agencies.
The disclosure is required by any judicial or administrative proceeding.
The disclosure is required by law enforcement.
The disclosure is required by a medical examiner.
The disclosure is deemed necessary to prevent or lessen a serious and imminent threat to the health and safety of you or to the public.
The disclosure is to another covered health care provider for its payment activities.
The disclosure is to another covered entity with which you also have a relationship and the information is used to prevent fraud, for treatment activities, or participation in organized health care arrangements.

We may change our policies at any time. We will post the change on the phase or unit office doors. You may request a copy of this notice at anytime. For more information, please contact John Short at P.O. Box 968 Travelers Rest, South Carolina, 29690, or you may leave a message for her at 864-836-7220, 110.

In the majority of cases, your access to your (PHI) information will be restricted, because the records are psychotherapeutic in nature. If you request copies of your PHI, we will respond in writing to your request. If a determination is made that a limited disclosure is warranted, then you will pay the cost of duplication and staff time, which is currently $0.25 per page. If you believe that the information contained in the records is incorrect, you may request an amendment thereof or add missing information.

Initials: ___________

**Patient's Name:________________________________**

## PHI / HIPAA NOTICE (con't)

HIPAA also gives you the right to request that your PHI be communicated to you in a confidential manner, such as sending mail to an address other than your home. If you receive this notice in electronic form, you may request a hard copy. It is also your right to request that we do not disclose your PHI, except when specifically authorized by you. We will consider your request, but we are not required to accept it. If you believe that we have violated your rights, or you disagree with decisions made regarding your PHI, then you may contact John Short at the above address. You may also contact the Department of Health and Human Services. John Short will provide you with an appropriate address. We will not retaliate against you for filing a complaint.

By law, we are required to protect the privacy of your PHI, provide this notice to you, and follow the practices in this notice.

ACKNOWLEDGED ON THIS ______ DAY OF ___________, 20___.

| ________________________________ | ________________ |
|---|---|
| Case Manager | Date |
| ________________________________ | ________________ |
| Parent / Guardian | Date |
| ________________________________ | ________________ |
| Patient | Date |

Persons or Entities that may receive information on the patient admitted to the program are listed herein below.
NAME: ____________________
Relationship to patient: _____________________
Purpose of Disclosure: _____________________
Restrictions on Disclosure: __________________ __________________________________________
NAME: ____________________
Relationship to patient: ____________________
Purpose of Disclosure: ____________________
Restrictions on Disclosure: _________________ _______________________________________
NAME: ____________________
Relationship to patient: _____________________
Purpose of Disclosure: ____________________
Restrictions on Disclosure: _________________

**Patient's Name:________________________________**

**Therapeutic Visitation and Family Counseling Planning**

**Child's Name__________________________________________________**

PRTF recognizes and acknowledges the importance of engaging cooperative and willing parent(s), guardian(s), and other family in the process of family counseling for children in care. One element of this process includes visits by the aforementioned parties with resident Patients as approved by the placing entity and in compliance with the PRTF's visitation policies and procedures. The PRTF assumes no responsibility for ensuring that parties other than the resident patient will be accessible for visitation and/or therapy sessions. The PRTF will offer and provide family therapy sessions during these visits and include family counseling, if requested by the placement agency. The PRTF will report on the level of participation by all parties through Progress Summary Notes (PSN) and the Individual Plan of Care(s). Please sign and date below in the appropriate space of your agency's choice.

| Family Counseling Plan (YES) | Family Counseling Plan (NO) |
|---|---|
| Custodial Agency | Custodial Agency |
| Parent(s) | Parent(s) |
| Date ________/______/______ | Date ________/______/______ |

NOTE: If the choice is currently "NO", this can be amended at a later date dependent upon the child's degree of progress in the program and/or changes in the child's family circumstances.

**Patient's Name:**________________________________

## NEUROLEPTIC INFORMED CONSENT

I understand the neuroleptics (antipsychotics) may be very helpful in treating my child's/dependent's (child henceforth) clinical condition. Clozaril, Risperdal, Zyprexa, Seroquel, Geodon, Abilify, and Invega are neuroleptics. Haldol, Prolixin, and Navane are examples of older neuroleptics.

I understand that these medications may help my child think more clearly, feel less aggressive and hostile, and can decrease other psychiatric symptoms. Some of them may help my child's mood. If he/he/she takes these medications regularly, they may keep many of their symptoms from coming back. The prescribing health provider cannot guarantee how they will respond to any of these medications. The improvement associated with psychoactive medications may be permanent or temporary. The medication will not cure the illness, but is recommended to help control the symptoms. Without the medication the present mental condition may improve spontaneously, continue with little or no change, or worsen.

I have talked with a health care provider about common side effects seen with these medicines. We have talked about tardive dyskinesia (TD). I understand the TD can cause irreversible movements of my child's mouth, jaw, tongue, hands, feet, or body. I know it often happens when a person takes an older medication for a long time, and that it can occur spontaneously even when someone has never taken these medications. The newer neuroleptics can cause it too, but much more rarely than the older medications. Sometimes it shows up after medicine is stopped or decreased. I have been advised by a health care provider to report any symptoms of TD, or other problems related to my child taking their medication, as soon as possible.

Alternatives to treatment with medications are; no treatment, psychotherapy, and/or electroconvulsive therapy (the last is not used at this facility). These alternatives are not preferable to the recommended medication. I understand the prognosis for my child, with and without the recommended medication treatment.

A health care provider will try to answer any questions I have about these medications. We will work together if we need to change the dose of my child's medicine, switch from one medication to another, or stop my child's treatment. I understand that my child is expected to take these medications as prescribed by their prescribing health care provider for the treatment of their clinical condition.

| | |
|---|---|
| Case Manager | Date |
| Parent / Guardian | Date |
| Patient | Date |

**Patient's Name:**__________________________________

## Informed Consent to Perform HIV Testing

- HIV is the virus that causes AIDS.
- The only way to know if you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law protects the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- The PRTF medical staff will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I __________________________________, hereby, give my consent for my child ______________________________to be tested for the diagnosis of HIV infection. If my child is found to have HIV, I, hereby, agree to additional testing which may occur on the sample that is provided to determine the best treatment for my child and to help guide HIV prevention programs. I, hereby, give my consent to future tests to guide my child's treatment. I understand that I can withdraw my consent for future tests at any time.

The PRTF medical staff have answered any questions I have regarding HIV testing, and I understand they are available to answer other questions I may have in the future.

| ______________________________ | ______________ |
|---|---|
| Printed Name of Parent/Guardian | Relationship |
| ______________________________ | ______________ |
| Parent/Guardian Signature | Date |
| ______________________________ | ______________ |
| Patient Signature | Date |
| ______________________________ | ______________ |
| Case Agency Personnel (if applicable) | Date |

**Patient's Name:**_________________________________

## Consent for the Sharing of Educational Data and Information

I authorize the provider, Excalibur Youth Services, LLC./Avalonia Group Homes, Inc. and their managed entities, to have access to all educational data, tests, grades, IEP information, psychological testing, and information in any other form on the patient ______________________________. The appropriate County School District is also authorized and directed to provide this information to Excalibur Youth Services, LLC.,/Avalonia Group Homes, Inc. and their managed entities.

The appropriate school district and Excalibur Youth Services, LLC.,/Avalonia Group Homes, Inc. and their managed entities are authorized to obtain any and all educational related information or health information on the patient _______________________________, and to share the above information with the any other authorized educational entity.

All disclosures and use of the shared information shall comply with the Health Portability and Accountability Act of 1996. This consent shall continue while the patient is in residence with the above providers and up to six months thereafter.

Dated this _________day of ______, 2____.

| | |
|---|---|
| Case Manager | Date |
| Parent / Guardian | Date |
| Patient | Date |

## MEDICAL HOMEBOUND INSTRUCTION FORM

Dear Physician:
Thank you for your dedication in keeping students healthy and progressing academically and socially in the regular school environment to the extent that is appropriate. The below named student and his/her parent, legal guardian or surrogate parent has requested that the school district provide medical homebound instruction due to the student's inability to come to school as a result of an illness, accident, or pregnancy even with the aid of transportation. A district representative may contact you to discuss strategies to maintain the student in the school environment and to request additional information. The district superintendent or his/her designee must approve any student participating in a program for medical homebound instruction or hospitalization instruction. Please fully complete section II as indicated.

**SECTION 1 – STUDENT INFORMATION: (To be completed by school district personnel)**

| **Student's Name:** | **Date of Birth:** | **Age:** | **Grade:** |
|---|---|---|---|
| **School:** | **School District:** | **Is the Student classified as disabled?**<br>Yes No Category: | |

**SECTION II: MEDICAL INFORMATION: (To be completed by a *licensed* physician)**

Diagnosis of condition that prevents school attendance: (Attach additional information if needed)

**Prognosis and Treatment:**

**How does this medical condition impact educational performance?**

Medical condition prevents her from functioning successfully in a traditional classroom setting.

Beginning date of nonattendance: ______/_______/_______ Projected date of return: ______/_______/______

I certify that the above student cannot attend school because of illness, accident, or pregnancy, even with the aid of transportation but may profit from instruction given in the home or hospital.

Date:_______/______/_______ Phone# ____________________________ Address:

Printed Name: Physician's Signature:

**SECTION III – RELEASE: (To be completed by parent or by student, if eighteen or older)**

I authorize the release of medical, educational, or mental health information to school officials.

X Date: ______/______/______

Signature of Parent/Legal Guardian/Surrogate Parent (or student if eighteen or older):

**SECTION IV – AUTHORIZATION: (To be signed and dated by District Superintendent or Designee)**

I certify that school officials will consider whether the student now qualifies under Section 504 of the Rehabilitation Act of 1973 or is eligible for entry into programs for children with disabilities. I further certify if this is a student with a disability in accordance with State Board of Education regulations and if the student's medical homebound placement constitutes a change of placement, an IEP committee with parental involvement will develop an individualized education program (IEP). Medical homebound services are authorized to begin on or after ________/______/________

Superintendent's or Designee's Signature:

Revised 7/1/02; supersedes all previous versions

## IDENTIFYING INFORMATION:

| |
|---|
| Name: SS# |
| DOB: Grade: Sex: Race: |
| Special Education Classification: |
| Home District: |
| Last School Attended: |
| Parent: |
| Address: |
| |
| Phone: |
| Parental Rights Terminated: ☐ YES ☐ NO |

## PLACEMENT INFORMATION:

| |
|---|
| Agency Name: |

| |
|---|
| **CASE WORKER NAME:** |
| Address: |
| |
| Phone: |
| Fax: |

## GROUP HOME INFORMATION:

| | |
|---|---|
| Name: | Venice PRTF |
| Address: | 3683 South Industrial Blvd. |
| | Simpsonville, SC 29681 |
| Phone: | 864-884-9298 |

## ENROLLMENT INFORMATION:

| |
|---|
| GCSD School: |
| Date Enrolled: |
| Number of Days Enrolled: |
| Date of Special Ed Placement: |
| ❑ Classification: |
| Number of Days Enrolled in Special Education: |
| Date Withdrew: |
| ❑ Reason: |
| Notes & Records Requested:<br>(For Office Use Below)<br><br>Date Received: |
| Date Sent to School: |
| Date Sent to Betty: |
| H.S. date Scheduled received: |
| HB Form Received: |
| IEP Meeting Date: |
| Reeval. Date: |
| ESAR: |
| Requested Forms: |
| |
| |
| |
| |

POWERSCHOOL CODING:

| |
|---|
| Group Home Facility Field: RTF |
| Group Home Services Field: |
| |

**Change in student Placement:** **More Restrictive _____** **Less Restrictive _____**

**Social and Developmental Information Request**

We are trying to obtain specific information in order to plan the best educational program for your child. A parent's input regarding a child is valuable in obtaining a total picture. If you have any questions, please contact your child's homeroom teacher.

| | |
|---|---|
| | |
| Student's Name | Date of Birth |
| | |
| School Last Attended | Grade |

**DEMOGRAPHIC INFORMATION**

| *Female Parent/Primary Caregiver* | |
|---|---|
| Name: | |
| Address: | |
| Phone: | |
| Age: | |
| Occupation: | |
| Marital Status: | |
| *Female Parent/Primary Caregiver* | |
| Name: | |
| Address: | |
| Phone: | |
| Age: | |
| Occupation: | |
| Marital Status: | |

*Siblings*

| Name | Age | Sex (M/F) | Living at Home (Y/N) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*Other persons currently living in the home*

| Name | Age | Sex (M/F) | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## DEVELOPMENTAL HISTORY:

1. Give approximate ages at which the child:
   Sat up _______________Crawled ___________Walked alone _______
   Was toilet trained __________________ Spoke first words _____________
   Put words together in sentences _________________________________

2. Does/did your child differ noticeably from other children in her ability to play, work, follow directions, or communicate with others?
   ( ) Yes ( ) No

3. How would you describe:
   Your child's <u>ability</u> to learn?
   ( ) Average ( ) Above Average ( ) Below Average
   Your child's effort to learn?
   ( ) Average ( ) Above Average ( ) Below Average
   Your child's attitude towards school?
   ( ) Average ( ) Above Average ( ) Below Average

4. Does your child have sleep difficulties? ( ) yes ( ) no
   If yes, please describe: _____________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________

5. Does your child have poor eating habits? ( ) yes ( ) no
   If yes, please describe: _____________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________

6. What methods of discipline work *best* with your child? _____________________________
   _____________________________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________

7. Please describe any traumatic experiences your child has had (i.e., death in family, divorce, witness of violence, etc.).
   _____________________________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________

## EDUCATIONAL HISTORY:

1. What is the primary language spoken in the home? ___________________________

2. Are any other languages spoken in the home? ( ) yes ( ) no
   If yes, please list ______________________________________________________

3. What does your child do well? _____________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

4. What problems or difficulties do you think your child is having at school?
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

5. Has your child been privately tested? ( ) yes ( ) no
   By whom: __________________________________________________________

6. Has your child ever been served by any other agencies? (Mental Health Center, Department of Social Services, Developmental Disabilities and Special Needs, Department of Juvenile Justice, etc.)? ( ) yes ( ) no
   If yes, please explain: ______________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

## MEDICAL HISTORY

1. Did the mother have any illnesses or unusual health problems during pregnancy?
( ) yes ( ) no
If yes, please explain: ____________________________________________
____________________________________________
____________________________________________

2. Were there any complications during the birth of this child? ( ) yes ( ) no
If yes, please explain including length of hospital stay: ____________________
____________________________________________
____________________________________________

3. Birth Weight ____________________________________________

4. Was the baby premature? ( ) yes ( ) no If yes, How many weeks early? ________

5. Has the child had any major illnesses or injuries? ( ) yes ( ) no
If yes, please describe and list at what ages the illness or injury occurred: ________

6. Has the child ever been hospitalized? ( ) yes ( ) no If yes, please list the age of child at time of hospitalization, the length of the hospital stay, and the reason for hospitalization:
____________________________________________
____________________________________________
____________________________________________
____________________________________________

7. How would you describe your child's present health? ____________________

8. Is your child currently taking any medication? ( ) yes ( ) no If yes, list medications: ______
____________________________________________
____________________________________________
____________________________________________

9. Has your child ever been diagnosed with a medical condition (i.e. Tourettes, ADHD, Bipolar, Asthma, etc)? ( ) yes ( ) no If yes, pleas list condition(s):____________
______
____________________________________________
____________________________________________
____________________________________________

10. Is there a history of family mental health problems? ( ) yes ( ) no If yes, please explains: ____________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_________________

11. Please add any further information that you feel would be helpful. _____________
_____________________________________________________________________
_____________________________________________________________________
____________________________________________________________
__________________________________

______________________________________ ____________________
Signature of Parent/Legal Guardian/Surrogate Parent: Date:

**Contracted Medical Provider Demographic Information**

Name __________________ SS# _______________D.O.B._______________
Caseworker/DSS Name ___________________________ Phone No.________________
Date placed in Foster Care ___________________________________________________
Date place at PRTF ________________________________________
Reason placed in foster care _______________________________________________________
______
_____________________________________________________________________________
_______________________________________________________________________

Family involved: Yes No

If yes, Name _______________________________Relationship _____________

Address ______________________________________________Phone ____________

Please obtain medical records and send copy to:
______________________________
______________________________
______________________________
______________________________

Medical Records sent: Yes No If no, when can we expect records? _________

The following information is required before he/she will be seen at our offices:

Medicaid or Insurance Card
Immunization Records
List of Allergies

Initial Date Completed: ________________________________________________

Birth History/Problems: _____________________________________________________
______
______
_____________________________________________________________________________
_____________________________________________________________________________
_______________________________________________________________________

Significant Past Illnesses/Hospitalizations/Surgeries: ______________________________

Current Problems:

DrugAllergies/Reactions: ______________________________

Current Medications: ______________________________

Immunization Record: ______________________________

Social: History of Tobacco, Drug Use, Sexual Activity/STD's: ______________________________