Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

Name: _____ **DOB:** _____

Gender: MALE FEMALE **Social Security #:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Numbers:

Home: ( ) _____ Can we call you at Home? Yes No

Cell: ( ) _____

Work: ( ) _____ Can we call you at Work? Yes No

Email: _____

Marital Status (circle one): Single Married Divorced Separated

Race (circle one):

American Indian or Alaska Native	Black/African American	Chinese
Filipino	Guamanian or Chamorro	Korean
Hispanic White	Japanese	Other Asian
Native Hawaiian	Other Pacific Islander	Samoan
White/Caucasian	Other Race	

Ethnicity (circle one):

Cuban	Mexican/Mexican American	Not Hispanic or Latino
Other Hispanic or Latino	Puerto Rican	

Preferred Language (circle one):

English Spanish Chinese Italian Polish Russian French Turkish Other

Known Allergies: _____

Employer: _____ **Occupation:** _____

Are you a Student? Yes No **If yes, Name of School:** _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Primary Care Physician: _____ **Phone #:** _____

Address: _____

Therapist Name: _____ **Phone #:** _____

Discipline: _____

Preferred Pharmacy Name: _____ **Phone #:** _____

Pharmacy Address: _____

EMERGENCY CONTACT:

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

PRIMARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

SECONDARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

For Partial Hospitalization Clients Only

Will you be driving to the program? _____

Make/Model/Plate #: _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

MS4365

Patient Name: _____ Date of Birth: _____

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: _____ Date: _____

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Part A
Brief Medical Screening

Doctor's Name:	Address:	Phone Number:	**Date of Last Exam**:
Dentist's Name:	Address:	Phone Number:	**Date of Last Exam**:

Has a Doctor EVER told you that you had any of the following conditions?

Condition	Check One		Currently Under a Doctor's Care	Comment
	Now	Past		
Alzheimer's Disease or Dementia	☐	☐	☐ No ☐ Yes	
Blood Sugar-High	☐	☐	☐ No ☐ Yes	
Blood Pressure (High)	☐	☐	☐ No ☐ Yes	
Cancer	☐	☐	☐ No ☐ Yes	
Deafness or other hearing impairment	☐	☐	☐ No ☐ Yes	
Diabetes	☐	☐	☐ No ☐ Yes	
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	☐	☐	☐ No ☐ Yes	
Epilepsy/Seizures	☐	☐	☐ No ☐ Yes	
Heart Attack	☐	☐	☐ No ☐ Yes	
Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides)	☐	☐	☐ No ☐ Yes	
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis	☐	☐	☐ No ☐ Yes	
Kidney Disease	☐	☐	☐ No ☐ Yes	
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	☐	☐	☐ No ☐ Yes	
Mobility Impairment	☐	☐	☐ No ☐ Yes	
Other Cardiac Condition	☐	☐	☐ No ☐ Yes	
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	☐	☐	☐ No ☐ Yes	
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	☐	☐	☐ No ☐ Yes	
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	☐	☐	☐ No ☐ Yes	
Sight Impairment	☐	☐	☐ No ☐ Yes	
Speech Impairment	☐	☐	☐ No ☐ Yes	
Stroke	☐	☐	☐ No ☐ Yes	
Traumatic Brain Injury	☐	☐	☐ No ☐ Yes	
Weight (Obesity, Unexplained Gain or Loss)	☐	☐	☐ No ☐ Yes	
Other physical related health conditions	☐	☐	☐ No ☐ Yes	

Organization Name:	Program Name:	Date:
Individual's Name (First MI Last):	**Record #:**	**DOB:**

CURRENT Medication Information ☐ **None**

(Include all current medication-Psychiatric/Non-Psychiatric, Prescription/Over-the-counter drugs/Herbal)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	

Additional:

Medication HISTORY Information ☐ **None**

(As best as possible, list all additional medications taken for psychiatric or substance abuse issues in the past)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	

Additional - Are there any medications you would like to avoid taking in the future?:

Allergies/Drug Sensitivities ☐ None

☐ Food (specify):

☐ Medicine (specify):

☐ Latex / ☐ Other (specify):

Medical hospitalizations/significant operative and invasive procedures?

☐ No ☐ Yes If yes, complete information below:

Hospital	Date	Reason

Comments:

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Nutrition/Hydration Screening Check if you have experienced:

1. ☐ **Any weight loss or gain of 10 pounds or more in the past three months**
2. ☐ **Change in appetite**
3. ☐ **Are you experiencing any other problems eating or drinking?**

The Joint Commission

Pain Screening

Do you have any ongoing pain problems? ☐ No ☐ Yes If yes, Medical Staff completes pain section below.

For Women Only

Currently pregnant?

☐ No ☐ Yes - If yes, expected delivery date:

Are you currently breastfeeding? ☐ No ☐ Yes

Receiving pre-natal healthcare?

☐ No ☐ Yes – If yes, indicate provider:

Any significant pregnancy history?

☐ No ☐ Yes – If yes, explain:

Menstruation

Last menstrual Period Date:

Menstrual Pain: ☐ No ☐ Yes

Menstrual Irregularities: ☐ No ☐ Yes ☐ Other:

Pre-menstrual symptoms: ☐ No ☐ Yes

Polycystic Ovary Syndrome? ☐ No ☐ Yes

If yes, Indicate provider:

For Children Only

Immunizations: Has the child or adolescent been immunized for the following diseases? Please check all that apply.

☐ Chicken Pox ☐ Diphtheria ☐ German Measles (rubella) ☐ Hepatitis B ☐ Measles ☐ Mumps

☐ Polio ☐ Small Pox ☐ Tetanus ☐ Other:

All immunizations up to date? ☐ Yes ☐ No – Comments:
Prenatal exposure to Alcohol or other Drugs? ☐ Yes ☐ No – Comments:
Any other significant information that may affect care or place the child or adolescent at risk (for example, accidents or injuries):

Completed By - Print Name:	**Signature:**	**Date:**

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Part B. Medical Assessment – (To be completed by Medical Staff/Reviewer)

Vital Signs/Physical Health Indicators
(Required, Where Indicated, For PROS W/CLINIC & Vitals Required for COA Opioid and Strongly Recommended for Others)

Blood Pressure:	**Abdominal girth:**	**Temperature:**	**Pulse:**
Respiration:	**Height:**	**Weight:**	**BMI:**

Nutritional/Hydration Status

If individual answered yes to any of the items in Nutrition/Hydration Screening above, provide referral information below or rationale if no further action taken:

Does individual have any medical concerns that may interfere with treatment or for which s/he needs assistance? ☐ No ☐ Yes
If Yes, explain:

Pain Assessment

Individual has pain based on Pain Screen section above: ☐ No ☐ Yes If yes, complete:

Site #1	**Site #2**
Location:	Location:
Description:	Description:

Pain is adequately controlled: ☐ No ☐ Yes
If no, is individual under medical care: ☐ No ☐ Yes - ***If no, make referral and document below:***

Actions Taken

OASAS

For those between the ages of 13 and 64: If HIV Test was negative, has the medical provider offered an HIV test? ☐ No ☐ Yes If no, explain:

Did the undersigned check the Prescription Drug Monitoring Program (PDMP) for this individual?
☐ No ☐ Yes If no, provide reason:

Physical Exam Information

OASAS

☐ No Physical Exam within the past 12 months; within 45 Days the individual will:
- ☐ Have a physical exam ***[Residential-Attach Copy]***; or
- ☐ Have a face-to-face assessment by a medical staff member to determine the need for a physical exam ***[Outpatient-See Referral Section Below]***; or
- ☐ Be referred for a physical examination ***[Outpatient-Complete Referral Information Below].***

☐ Physical Exam within the past 12 months or admitted directly to the service of another OASAS-certified service; the medical history and physical examination (including required laboratory tests) from such other services or physicians, (dated:) has been reviewed and determined to be current and accurate by:

- ☐ clinical or medical staff member ***[Residential Signature & Credentials: Date:]; or***
- ☐ medical staff member ***[Outpatient Signature & Credentials: Date:].***

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

The Joint Commission

Was Last physical completed more than one year ago? ☐ No ☐ Yes - If Yes, document referral below:

Referrals and Recommendations

OASAS

Based on Face to Face Medical Assessment:

☐ **Individual requires physical exam- see referral below, OR**

☐ **Individual does not require physical exam**

☐ Nutrition/Hydration Referral:
☐ Pain Referral:
☐ Specialty Care:

☐ Primary Care Physician (General Referral):
☐ Primary Care Physician for Physical Exam and Date, if known:

☐ Other:

Comments, if indicated:

Completed By - Print Staff Name/Credentials:	**Staff Signature:**	**Date:**