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: _____

Mather Hospital
Northwell Health®

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

Telehealth involves the use of electronic information and communication technologies to enable healthcare providers to remotely provide healthcare services to patients.

Services Provided:
Telehealth services offered by Northwell Health, Inc. (Northwell) through its providers may include consultation, diagnosis, assessment, treatment, education, care management and/or self-management (Services).

The information you provide may be used for:

- A review of health records, images, and/or test results
- Live two-way interactive audio and video; and/or
- Reviewing output data from medical devices

The electronic communication systems we use will incorporate security protocols to protect your privacy and will include measures to protect your data against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by allowing you to remain in your home or at a doctor's office while another provider consults on your care.
- More efficient evaluation and care management.
- Obtaining expertise of a specialist, as appropriate.

Possible Risks:

- Delays in evaluation and treatment could occur due to failures of the equipment and technologies.
- A telehealth provider may decide that the transmitted information is of poor quality. If this is the case, you may need to reschedule the telehealth consult or meet with your local primary care doctor.
- Although unlikely, security protocols could fail, causing a breach of privacy of personal medical information.

Service Limitations:

- Our providers do not address medical emergencies. If you believe you are experiencing a medical emergency, you should dial 9-1-1 and/or go to the nearest urgent care center or emergency room.

By checking the box below, you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving the Services via telehealth. I understand that it is up to the Northwell telehealth provider to determine whether my specific clinical needs are appropriate for a telehealth encounter.
2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Northwell will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners who may be located in other areas, including out of state.

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Northwell. I agree to hold Northwell harmless for delays in evaluation or for information lost due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth Services at any time for any reason or for no reason.
5. I understand that I will be directed to contact emergency medical services or dial 9-1-1 immediately in the event of a medical emergency.
6. I understand that alternatives to the telehealth Services, such as in-person Services are available to me, and in choosing to participate in the telehealth Services, I understand that some parts of the telehealth Services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Northwell provider (e.g., labs or blood work).
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons, other than the Northwell telehealth provider, may be present during the telehealth Services in order to operate the telehealth technologies.
9. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
10. I understand that I will be responsible for all copays and deductibles associated with the telehealth Services that I receive. To the extent that I do not have insurance or to the extent that I have insurance that does not cover the telehealth Services, I acknowledge and agree that I will be responsible for the costs of the telehealth encounter. I have been able to ask questions regarding any costs that I may incur and my questions have been answered to my reasonable satisfaction.
11. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.
12. To the extent that I receive group therapy Services via telehealth, I understand and agree that (a) I must participate in a private location, (b) I am not to record the telehealth encounter, (c) I am not to invite or allow others who are not participants in the group to view or listen to the encounter, and (d) I must keep the ID, password and link to the virtual group encounter confidential. Upon the conclusion of a group therapy session or if I need to leave a group therapy session before it concludes, I agree to promptly logoff of the electronic communications technology platform used to conduct the Services. To the extent that I violate the terms of this Section 11, I understand and acknowledge that my participation in the session may be terminated, and I may no longer be able to participate in the group therapy Services via telehealth.

Mather Hospital
Northwell Health®

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

Patient Consent:

I have read this document carefully, I understand the risks and benefits of the telehealth Services, I have had my questions regarding the procedure explained, and give my consent to participate in the telehealth Services under the terms described herein.

❑ **ACCEPT.** By checking the Box for this **"CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES"** I hereby state that I have read, understood, and agree to the terms of this document.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name (Relationship if other than patient)
Telephonic Interpreter's ID#	Date	Time	

OR

Interpreter (Signature)	Date	Time	Interpreter's Name and Relationship to Patient (Print)
Witness to Signature (Signature)	Date	Time	Witness Name (Print)

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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:**