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: _____

John T. Mather Memorial Hospital
Mental Health Clinic

RECIPIENT RIGHTS

As a recipient in a mental health clinic in New York State you have the right, consistent with law, to:

1. An individualized plan of treatment services and to participate to the fullest extent, consistent with the recipient's capacity, in the establishment and revision of that plan.

2. A full explanation of the services provided in accordance with their treatment plan.

3. Voluntarily participate in treatment. Recipients in an outpatient program are presumed to have the capacity to consent to voluntary treatment. The right to participate voluntarily in and to consent to treatment shall be limited only pursuant to a court order or in accordance with applicable provisions of law.

4. While the recipient's full participation in treatment is a central goal, a recipient's objection to his or her treatment plan, or disagreement with any portion thereof, shall not, in and of itself, result in the recipient's termination from the program unless such objection renders continued participation in the program clinically inappropriate or would endanger the safety of the recipient or others.

5. Confidentiality of clinical records in accordance with applicable State and Federal laws and regulations, which may include, but are not limited to section 33.13 of the Mental Hygiene Law, Article 27-F of the Public Health Law, the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2.

6. Recipients shall be assured access to their clinical records, including their mental illness diagnosis, consistent with section 33/16 of the Mental Hygiene Law and applicable Federal requirements.

7. Receive clinically appropriate care and treatment that is suited to your needs and skillfully, safely and humanely administered with full respect for your dignity and personal integrity.

8. Receive services in such a manner as to assure non-discrimination.

9. Be treated in a way which acknowledges and respects your cultural environment.

10. A reasonable degree of privacy consistent with the effective delivery of services.

11. Freedom from abuse and mistreatment by employees.

12. Be informed of the provider's recipient grievance policies and procedures, and to initiate any question, complaint or objection accordingly. If you are not satisfied with the results of the grievance process the following agencies are available for you to contact.

The Justice Center for the Protection of People with Special Needs
(800) 624-4143

For the "Protection and Advocacy for Mentally Ill Individuals Program" (PAIMI)
Disability Rights New York
1-(800) -993-8982

National Alliance on Mental Illness (NAMI) - New York State
1-(800) – 950-3228

National Alliance on Mental Illness (NAMI) – Central Suffolk
631-675-6831

New York State Office of Mental Health
1-(800) 597-8481

I have read and understand the above Recipient's Bill of Rights, they have been explained to me and my questions have been answered.

_____ _____
(Recipient Signature) (Date)

_____ _____
(Parent or Guardian Signature) (Date)

MATHER
JOHN T. MATHER MEMORIAL
HOSPITAL

MENTAL HEALTH CLINIC

CONSENT FOR TREATMENT

I agree to voluntarily participate in treatment at the Mather Hospital Mental Health Clinic.

I. I understand and agree with the responsibilities to:

1. Actively and earnestly cooperate with treatment by providing the necessary information and cooperating with the therapeutic interventions recommended by my treatment provider.
2. To participate in the development of my treatment plan and discharge plan.
3. Keep scheduled appointments, or if it is necessary to cancel an appointment, to notify the Office 24 hours in advance so that the time may be allotted to another client. Failure to give appropriate notice for cancelling 3 appointments in a 12 month period will result in the clinic withdrawing from further professional attendance to me.
4. Pay for treatment services at the time that they are delivered. If covered by an insurance plan that my provider is "in network" with, I will be responsible for the applicable co-pay and deductible that is determined by my insurance company.
5. Not smoke while in the office.
6. Conduct myself in a respectful manner towards other recipiants and staff members.
7. Honor this commitment, as failure to comply will result in my treatment provider withdrawing from further professional attendance to me.
8. I acknowledge that no guarantee has been made to me as to the result of treatment and I certify that I have read and fully understand the consent given herein.

_____ _____

Witness **Patient (18 years or above)**

_____ _____

Date **Parent or Guardian**

II. Additional Information:

1. I acknowledge receipt of the following information on Advance Directives: 1) Planning in Advance for your Medical Treatment (an explanation of Advance Directives, 2) Deciding about CPR: Do Not Resuscitate (DNR Orders) – A Guide for Patients and Families, 3) Appointing Your Health Care Agent – New York State's Proxy Law, 4) Health Care Proxy form.
2. I acknowledge receipt of the Privacy Notice outlining my rights regarding confidential protection health information.
3. I have reviewed the following Greviance Process:

   A. Client's are encouraged to verbally express their opinions of agreement or disagreement with their treatment plan or discussing their appointment with the staff.

   B. When the above avenues are insufficient for resolution of the client's complaint, the client is encouraged to utilize the grievance outlined below:

      1. Submit a written description of the complaint which is signed and dated, to the Director of Mental Health Clinic, which includes WHO and WHAT the complaint is about, WHAT (i.e. the treatment plan) and WHEN it occurred.

      2. The Director of Mental Health Clinic will review the complaint and respond within three program days. If the client is not satisfied with the response he/she may resubmit the complaint to the Vice President of Nursing who will respond within three program days. If not satisfied with the response the client can request a review by the Office of Mental Health by calling (800) 597-8481.

_____ _____

Patient (18 years or above) or Parent or Guardian **Date**

MATHER
John T. Mather Memorial
HOSPITAL

MENTAL HEALTH CLINIC
125 OAKLAND AVENUE • SUITE 303 • PORT JEFFERSON • NEW YORK 11777 • 631-729-2140 • FAX 631-729-2144

Outpatient Behavioral Health Services

Mental Health Clinic

Effective January 1, 2015, we will be initiating a new attendance policy.

We expect that every effort will be made to keep appointments and have consistent attendance. In the event you have to cancel an appointment, we request that you call at least 24 hours in advance so that we may utilize that spot for another patient.

If you cancel less than 24 hours of your appointment time or NO SHOW, we will be sending out a letter alerting you that you have missed an appointment. Each letter will alert you that it is your first, second or third missed appointment.

Once you've reached three missed appointments without proper notice, the next letter that you will receive would be a discharge letter. This letter will state that we will be available for the next 30 days for emergency telephone calls and we will give you a 30 day supply of medication while you transfer to another provider. In the event that you need emergency treatment; we will direct you to the nearest emergency room.

I have read the above attendance agreement and agree to comply.

Signature _____

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:**