Valle Vista Health System

MEDICAL SCREENING QUESTIONNAIRE

Name: ______________________________ Date Completed: ______________

Name of Family Physician: ______________________________

YES	NO	
☐	☐	Current Physical illness. If yes, please explain: ______________________
☐	☐	Have you had a temperature in the past 24 hours?
☐	☐	Have you had any nausea, vomiting or diarrhea in the past 24 hours?
☐	☐	Do you have a sore throat?
☐	☐	Do you currently have an IV, heparin lock, subclavian IV?
☐	☐	Do you need assistance with walking, bathing, or other physical activities? If yes, please list. ______________________
☐	☐	Have you had any recent head injuries?
☐	☐	Have you had any recent loss of consciousness?
☐	☐	Have you ever tested positive for tuberculosis?
☐	☐	Have you ever had an active infection of MRSA or VRE?

In the last month, have you or your family been exposed to or had:

Y	N		Y	N		Y	N	
☐	☐	Chicken pox	☐	☐	Head lice	☐	☐	Chronic Cough
☐	☐	Measles	☐	☐	Scabies	☐	☐	Spitting Blood
☐	☐	Mumps	☐	☐	Venereal Disease/	☐	☐	Loss of Appetite
☐	☐	Strep throat			Sexually transmitted disease	☐	☐	Night Sweats
☐	☐	Hepatitis	☐	☐	Tuberculosis	☐	☐	Weight Loss
☐	☐	Diarrhea	☐	☐	Previous TB Test? Date ______	☐	☐	Weakness

If any of the above are checked "YES", please inform RN.

Unit Staff Member: ______________________________ RN was informed of medical concerns from the Screen at (time) ______________

______________________________ ______________

Signature - Assessment Referral Staff Date

Children/Adolescents Only	Yes	No	Date/Age/Describe:
Chicken Pox	☐	☐	
Mumps	☐	☐	
Scarlet Fever	☐	☐	
Rubella	☐	☐	
Rubeola	☐	☐	
Immunizations are Current	☐	☐	(Youth only)

DTP and/or Tetanus 1___ 2___ 3___ 4___ 5___ Rubella (German Measles) 1___ 2___

Oral Polio 1___ 2___ 3___ 4___ Mumps 1___ 2___

Measles 1___ 2___ Hib 1___ 2___ 3___ 4___

☐ Parent indicates immunizations are up to date but dates are unavailable.

☐ Parent indicates immunizations are not up to date, instructed to follow up with physician after discharge.

Education Release of Information Consent Form Signed: ☐ Yes ☐ No (Youth only)

PLEASE OBTAIN COPY OF IMMUNIZATIONS IF AVAILABLE.

Nursing Home Clients:

☐ ☐ PPD Skin Test/chest x-ray in the last seven days?
If no, instuct nursing home to complete.
If yes, results ______________________________

☐ ☐ Patient has indwelling catheter and /or any open wounds?
If yes, request a MRSA and a VRE culture:
Results: ______________________________

If active TB or MRSA/VRE, please notify MD and arrange for appropriate medical care.

EDUCATION AUTHORIZATION FOR RECEIPT, USE OR RELEASE OF INFORMATION

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize: Valle Vista Health System
898 East Main Street, Greenwood, IN 46143
317-887-1348

To receive, use or release health information and records obtained during the course of treatment of:

Patient Name: ______________________ Date of Birth: ______________
Address: ______________________ Patient's Phone: ______________
____

Grade Level: __________

1. The information is to be received from or used or disclosed to the following school:

Home School

School /Individual: ______________________________
Address: ______________________________
Phone: ______________________________

2. Purpose: The purpose of the receipt, use or disclosure is:
   As needed for guidance and educational planning during treatment and upon return to school;
   To determine immunization status of patient.

3. Information to be used or disclosed.
   The information to be used or disclosed includes only those items indicated below, with respect to services provided on or around (insert dates of service): ______________. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge.

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

Immunization Records
Teacher/Counselor Observations and Ratings
Principal Disciplinary Reports
School Permanent Record
Individual Educational Plans
Psychoeducational test results

Physician Discharge Summary (from Valle Vista Health System)
Educational Discharge Summary (from Valle Vista Health System)
Continuing Care/Discharge Planning Form (from Valle Vista Health System
Verbal communications

Patient's Name ____________________________

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Valle Vista Health System from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If requested information may be faxed. ☐ **Yes** ☐ **No** **Initial if Yes** ______

If patient is a minor, relevant state law should be followed with respect to the required signators. Valle Vista Health System will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire upon occurrence of the following event or condition. If none are checked, the authorization will expire 180 days past date of signature.
   - ☐ 180 days past termination of services at Valle Vista Health System from the date this authorization is signed or
   - ☐ at the happening of the following event or date (less than 180 days from date signed): ______________________________
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Valle Vista Health System will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):
   - ☐ The patient, and the identification that I have provided is true and correct.
   - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: __________________________".
5. **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

(Date)	Patient Signature	(Date)	(Parent/Guardian Signature)

(Date)	Staff Member/Witness Signature	(Print Last Name)

(INTERNAL USE ONLY)

I have received ____________________ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

(Date)	(Employee Signature)	(Printed Name)

PLEASE NOTE:
Patients attending Valle Vista's school program receive high school credits from Greenwood Community Schools.

AUTHORIZATION FOR RECEIPT, USE OR RELEASE OF INFORMATION

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize: Valle Vista Health System
898 East Main Street, Greenwood, IN 46143
317-887-1348

To receive, use or release health information and records obtained during the course of treatment of:

Patient Name: ______________________ Date of Birth: ______________
Address: ______________________ Patient's Phone: ______________
____

1. The information is to be received from or used or disclosed to the following school(s):

☐ Greenwood High School	☐ Greenwood Middle School	☐ Isom Elementary School	☐ Special Services
615 W Smith Valley Rd	523 S Madison Ave.	50 E. Broadway	Johnson Co. Schools
Greenwood, IN 46143	Greenwood, IN 46142	Greenwood, IN 46143	500 Earlywood Dr.
317-889-4000	317-889-4047	317-889-4070	Franklin, IN 46131
Fax: 317-889-4039	Fax: 317-889-4044	Fax: 317-889-4115	317-736-8495
			Fax: 317-738-7226

2. Purpose: The purpose of the receipt, use or disclosure is:
   At the request of the patient and
   Other –school enrollment and educational needs

3. Information to be used or disclosed.
   The information to be used or disclosed includes only those items indicated below, with respect to services provided on or around (insert dates of service): ______________________. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge.

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

__X__ Discharge Summary (if requested)
_____ Psychiatric Evaluation
_____ Treatment Plans
_____ Laboratory Data and PPD
_____ Consultation Reports
_____ Assessments
_____ Billing/Financial Records
_____ History and Physical Exam
_____ Psychological Testing
_____ Progress Notes
_____ X-ray Report
_____ Medication Records
__X__ **Continuing Care/Discharge Plan**
__X__ **Educational records**

04/2010

_____ Letter with date and physician name
_____ Letter with date, physician name, and diagnosis

__X__ **Educational Case Conferences**

Patient Name ________________________________
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This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Valle Vista Health System from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If requested information may be faxed. ☒ **Yes** ☐ **No** **Initial if Yes** ______

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4. **Certification:** I certify that I am (check whichever applies):
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   - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: ______________________________".
5. **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

______	______	______	______
(Date)	Patient Signature	(Date)	(Parent/Guardian Signature)
(Date)	Staff Member/Witness Signature	(Print Last Name)	

____
(INTERNAL USE ONLY)

I have received ________________ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

______	______	______
(Date)	(Employee Signature)	(Printed Name)

Valle Vista Health System
Residential Treatment Center - Consents and Acknowledgments

Patient Name: ______________________________

CONSENT FOR RELIGIOUS SERVICES
The program of the Residential Treatment Center is multi-disciplinary. In other words, the program integrates a variety of treatment approaches to meet the needs of the children and adolescents served by the program.

Religious services are available to each child and adolescent if he or she desires to participate in them. Although not affiliated with any particular denomination, these services are Christian. They include but are not limited to worship services on Sunday morning, traditional Sunday school, and individual pastoral counseling. Those professionals providing religious services recognize that spirituality has a variety of expressions. As a result, they are sensitive to this diversity, and encourage spiritual expressions, which contribute to the overall mental health of the patients served.

Consent: ☐ Yes ☐ No

CONSENT TO PARTICIPATE IN CLASSES ABOUT HUMAN SEXUALITY
The Residential Treatment Center (RTC) Program recognizes that emotionally disturbed and/or chemically dependent adolescents are vulnerable to sexual exploitation and/or precocious sexual activity. We believe that by providing adolescents with information about human sexuality appropriate to their age and by encouraging them to discuss that information in a group format, they will be better prepared to act appropriately upon discharge.

Consent: ☐ Yes ☐ No

CONSENT FOR TUBERCULIN SKIN TEST
A TB skin test will be administered upon admission and annually thereafter if still a patient at Valle Vista Health System. I acknowledge that he/she has not tested positively previously to a TB skin test or has not been treated for TB.

Consent: ☐ Yes ☐ No

CONSENT FOR IMMUNIZATIONS
Patients will receive immunizations and updates as recommended by the Indiana State Department of Health in order to meet compliance requirements. I understand that immunizations will be updated, if required, according to the immunization records that have been provided to Valle Vista Health System and will be administered by our nursing staff or at the Health Department.

Consent: ☐ Yes ☐ No

COMMUNICABLE DISEASE ACKNOWLEDGMENT
I acknowledge that the above named patient has not been exposed to any communicable diseases within the past three (3) weeks prior to his/her admission to Valle Vista Health System.

☐ Yes ☐ No

ACKNOWLEDGEMNT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge receipt of Valle Vista Health System's Notice of Privacy Practices. (Document is on file at the county office designated in the Individual Child Placement Agreement of Indiana Department of Children Services.)

☐ Yes ☐ No

ACKNOWLEDGEMNT OF RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES
I acknowledge receipt of Valle Vista Health System's RTC Patient Rights and Responsibilities. (Document is on file at the county office designated in the Individual Child Placement Agreement of Indiana Department of Children Services.)

☐ Yes ☐ No

______________________________ ____________
Parent/Guardian Signature Date

______________________________ ____________
Witness Signature Date

Rev 04/2010

Valle Vista Health System
Visitation and Phone List

Patient Name: ______________________________ Medical Record # ____________

Visitation Support Person:

Name	Relationship to Patient

Visitation List for **immediate** family members:

Name	Relationship to Patient

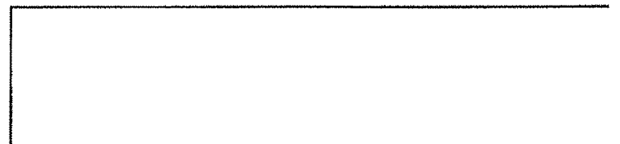
Visitation List for other involved parties (i.e. CASA, probation, clergy, etc.) (Should be included on Release of Information form)

Name	Relationship to Patient	ROI Obtained
		☐
		☐
		☐
		☐

Phone List for **immediate** family members:

Name	Phone Number

(A valid Authorization for Release of Information form must be obtained prior to releasing any patient information, verbal or written.)



VV-980-2
(01/2011)

Valle Vista Health System
Philosophy and Practice for Seclusion & Restraint Use
RESIDENTIAL TREATMENT CENTER

WHAT IS THE PHILOSOPHY OF THE RESIDENTIAL TREATMENT CENTER REGARDING SECLUSION & RESTRAINT USE?

Valle Vista Health System promotes the use of non-physical interventions and seclusion/restraint is used as the last resort to support the safety of the patient and/or others. The facility is committed to prevent, reduce and eliminate the use of seclusion/restraint through early identifications of high-risk behaviors or events. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions.

WHAT IS SECLUSION AND RESTRAINT AND WHEN ARE THEY USED?

Seclusion is any involuntary confinement of a patient alone in a room or area where he/she is physically prevented from leaving or the perception is given to the patient that he/she is unable to leave the room.

Restraint is a hold that involuntarily restricts a patient's freedom of movement, activity or normal access to one's body.

Seclusion or restraint is used when it has been determined that it will be the least restrictive intervention that will be effective to provide immediate physical safety of the patient, a staff member, or others and it is discontinued at the earliest possible time. They require a physician's order and are **never** used as a form of discipline, punishment or convenience for the staff.

WHAT ALTERNATIVES ARE TRIED BEFORE USING SECLUSION OR RESTRAINT?

Staff use a variety of alternatives to try and avoid the use of seclusion/restraint. These options may include:

- Giving the patient clear instructions and directions about his/her behavior.
- Encouraging the patient to talk about what's making him/her angry and/or frustrated.
- Reducing negative stimuli in the patient's environment e.g. loud noises, turning out lights, allowing the patient alone time.
- Offering diversionary and physical activities e.g. music, exercise, reading.
- Providing medications that the physician has ordered to help the patient to relax/gain control of his/her emotions.
- Using information provided by the patient and/or family regarding what calms him/her.

WHAT BEHAVIORS WILL RESULT IN RELEASE FROM SECLUSION/RESTRAINT?

Patients are released from seclusion/restraint when they demonstrate behavioral control, show improved ability to understand and follow directions and are no longer dangerous to themselves, other patients and/or staff.

HOW CAN YOU HELP?

If you are aware of events in the past that you think may assist with these behaviors, or if you are aware of methods that have been used in the past that were helpful, please inform the staff. To the extent that it is possible, we will incorporate this information into the treatment plan.

❑ If a seclusion/restraint intervention is used during your hospital stay, who would you want to be notified?

Name: ________________________ Phone #:__________________________

❑ I do not want anyone to be notified.

The parent/guardian will be notified when seclusion/restraint is used and the reason for this intervention in all cases with minors (patient younger than 18 years of age)

PATIENT SIGNATURE ____ **DATE** ____________________

PARENT/GUARDIAN SIGNATURE ____________________________________ **DATE** ____________________

STAFF SIGNATURE ____ **DATE** ____________________