**Referral Form: School Staff**

Name of student: _____ DOB: _____ Grade: _____

Your name: _____ Relationship to student: _____

Our provider may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone: _____ Best time to contact: _____

**Area of concern (please describe):**

__ Behavioral Concerns:
__ Social Concerns:
__ Emotional Concerns:
__ Physical Health Concerns:
__ Family Concerns:
__ Other: _____

**Behavioral concerns (please mark all that apply):**

__ Exposed to community violence, other
__ Hopelessness, negative view of future
__ Anxious, fearful or irritable mood
__ Jumpy or easily startled
__Low or decreased motivation
__ Sexualized play or behaviors
__ Talks excessively
__ Specific fears or phobias
__ Inattentive, distractible, forgetful
__ Disorganized, makes careless mistakes
__ Fights and is aggressive
__ Sad, depressed or irritable mood trauma
__ Low self-esteem, negative self-statements
__ Difficulty concentrating
__Diminished interest in activities
__ Aggressive
__ Worries excessively
__ Gets out of seat and moves constantly
__ Interrupts and blurts out responses
__ Clingy behavior
__ Angry towards others, blames others
__ Argumentative and defiant

How often is behavior occurring? _____
How long has this been occurring? _____
What interventions have been previously tried?_____
_____
_____
_____

Have the parent(s)/guardian(s) been notified of the issue? __ Yes __ No
Contact information for parent(s)/guardian(s):
Name: _____ Phone: _____

# CONSENT FOR SERVICES

| Students Full Name | Date of Birth | Social Security # |
|---|---|---|
| _____ | _____ | _____ |

At Sterling Health Care, we strive to provide the most comprehensive care possible for our patients. That is why we have expanded our services in your area and are partnering with Paris City Schools to offer school-based behavioral health services. Our providers will work to provide the best care possible for your child in the school setting.

In the process of providing school-based care our providers will only share patient information when clinically necessary to improve the overall well-being or safety of your child. Any pertinent information that is shared will only take place between our provider and the appropriate PCS staff member(s) to ensure the best clinical outcome and highest regard for protecting our patient's privacy.

In order to provide in school services, we will need you to complete the consent below:

I _____ give consent for my child _____ to receive school-based behavioral health services in the Paris City School system from Sterling Health Care.

I also give consent:

- For the Sterling Health Care staff to review my child's full school record, including attendance and information that will assist the staff in the continuity of care and treatment of my child.
- For Sterling Health Care staff to communicate and disclose behavioral health information with appropriate Paris City School Staff regarding my child's success at school and in the school setting.
- For Sterling Health Care School-Based Clinic to disclose to any appropriate agencies or medical practitioner any medical and billing information that may result through my child's contact with the School-Based Health Center.
- For the Sterling Health Care School-Based Clinic staff to obtain any records or information from any agency or private professional regarding my child's care. Sterling Health Care School-Based Clinic is released from all liability that may arise from the release of such information.
- I authorize Sterling Health Care to release medical information about me or my child to Medicare, KCHIP, Medicaid insurance and other third-party payers to determine payment for service.
- I request that payment of authorized medical insurance benefits be made to Sterling Health Care on my behalf for services received.

I understand that Sterling Health Care shall provide a copy of their Notice of Privacy Practices upon my request.

| Parent/Guardian Signature | Date |
|---|---|
| _____ | _____ |

# Authorization for Release of Information

**The undersigned hereby authorizes:**

| | | |
|---|---|---|
| Sterling Health Solutions<br>633 Maysville Road<br>Mount Sterling, KY 40353<br>Ph: (859) 404-7686<br>Fax: (859) 498-8160 | ***to release to***<br>**(OR)**<br>***procure from*** | *Paris City Schools*<br>*310 West 7th Street*<br>*Paris, KY 40361* |

**Information from the below listed patient/clinic record:**

**Patient Name: _____ Patient DOB: _____**

**Reason for Request:**

__Personal Interest __Continuity of Care __Transferring Care __Social Security/Disability Claim
__Legal Proceedings __Insurance Claims Processing __Other: _____

Date(s) of Service(s) to be released: ___**All**_____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization. This authorization will terminate on the following date, event or condition: _____. If no date, event or condition specified, this authorization will expire in ***one year*** from the signature date. I also understand my refusal to sign this authorization will not affect my ability to obtain treatment, payment for services or eligibility for benefits. If a service is requested by a party other than the patient for the purpose of creating health information, refusal to sign this authorization may result in the service request being denied.

I understand I can cancel this authorization and to do so I must send a written request to Sterling Health as authorized above.

I understand I can obtain a copy of my health care data and to do so I must submit a written request to Sterling Health as authorized above.

I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law, ***except for drug and alcohol treatment information.***

**Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released:**

Please check the appropriate item(s):

__Psychotherapy Notes __Psychosocial Assessment __Treatment Plan __Medications
__Group Therapy Notes __Medication Management Notes __Psychiatric Eval/Tests __Psychosocial Eval/Tests
__Discharge Summary __Labs __Other (Please Specify): _____

__Alcohol/Drug Treatment Records __Alcohol/Drug Assessments __Labs & Treatment Record

I understand that special permission must be given for the release of Mental Health/Drug and Alcohol/HIV results. I understand that by entering my signature below I am releasing the detailed information to the above listed person(s) or facility.
***** I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law. *****

Printed Name:_____ Relationship to Patient:_____

Patient/Parent/Guardian/Legal Representative Signature: _____ Date:_____

**FOR FACILITY PERSONNEL ONLY**

___Patient Identification Verified. Signature:_____ Date:_____

# STERLING HEALTH CARE - CHILD

**GUARDIANSHIP INFORMATION**

**Are you the child's legal guardian?** ☐Yes ☐No
If you marked no, who has legal guardianship? _____

****If you are not the biological or adoptive parent, you must provide legal documentation of guardianship****

**DEMOGRAPHIC INFORMATION**

**Last Name**: _____ **First Name**: _____ **Middle Name:** _____

**Nickname:** _____ **SSN:** _____ **Birth Date:** _____

**Race:** ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian ☐White ☐ Other
**Ethnicity:** ☐Hispanic/Latino ☐Non Hispanic/Non Latino

**Preferred Language:** ☐English ☐Spanish ☐Interpreter Needed

**Address:** _____ **Zip Code**: _____

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

**Email Address:** _____ **Preferred Communication**: Phone/Email

**Preferred Phone Contact**: ☐Home ☐Cell ☐Work
**Living Situation** ☐ Homeless ☐Transitional ☐Doubling Up ☐Street ☐Other ☐Unknown ☐Not Homeless
**Agricultural Worker** ☐ Migrant ☐Seasonal **Are you a Veteran?** ☐Yes ☐No

**In case of Emergency, please contact:**

**Name** _____ **Phone:** _____ **Relation:** _____

**Address** _____

**INSURANCE INFORMATION:**

**Primary Insurance:** _____ **ID#** _____ **GROUP#** _____
**Secondary Insurance:** _____ **ID#** _____ **GROUP#** _____
**Subscriber Name:** _____ **Subscriber Date of Birth** _____
**Subscriber Gender:** ☐Female ☐Male **Subscriber Phone** _____
**Subscriber Address if different from Patient:** _____

STERLING HEALTH CARE

## CHILD NEW PATIENT HISTORY

**ALLERGIES**

| | |
|---|---|
| Medications | |
| Vaccines | |
| Food | |
| Other | |

**CURRENT MEDICATION(S)**

| Medication Name | Dosage | Directions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**BIRTH HISTORY**

Was this child? ☐Full term ☐Pre-term ☐Adopted
If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? ☐Vaginal ☐ C-section If C-section, why? _____
Birth weight _____ Breech? ☐Yes ☐No

Any problems during the newborn period? ☐Yes ☐No
If yes, please explain_____
_____

**CHILD'S PAST MEDICAL HISTORY**

Any Hospitalizations? ☐Yes ☐No

| Reason for Hospitalization | Date of Hospitalization | Facility Where Hospitalized |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Any Surgeries? ☐Yes ☐No

| Type of Surgery | Date of Procedure | Facility Where Procedure Was Performed |
|---|---|---|
| | | |
| | | |
| | | |

**FAMILY HISTORY**

Is there a family history of mental health or substance abuse issues? __Yes __No
If so please list what and who:_____

_____

_____

**SOCIAL HISTORY**
Who lives in your child's home? _____

_____

Is your child in: ☐Daycare ☐School If so, what grade? _____

Do you have any concerns about your child's behavior? _____

_____

_____

Is there anything more you would like us to know about your child? ☐Yes ☐No

If yes, please explain _____

_____

_____

_____

_____

_____