STERLING
HEALTH CARE

Behavioral Health Referral Form

Name of School:_____Homeroom Teacher:_____

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
___Difficulty Sleeping
___Sexualized play or behaviors
___Talks excessively
___Specific fears or phobias
___Inattentive, distractible, forgetful
___Disorganized, makes careless mistakes
___Excessive sleeping (sleeping all day)
___Sad, depressed or irritable mood
___Low self-esteem, negative self-statements
___Difficulty concentrating
__Diminished interest in activities
___Verbal Aggression
___Physical Aggression
___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: _____

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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 Powell County 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 Powell County 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 Powell County 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

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Authorization for Release of Information

The undersigned hereby authorizes:

Sterling Health Care 633 Maysville Road Mount Sterling, KY 40353 Ph: (859) 404-7686 Fax: (859) 498-8160	***to release to*** **(OR)** ***procure from***	*Powell County Schools* *691 Breckinridge Street* *Stanton, KY 40380*

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: _____
Medical Records:
I authorize the following information to be released:
__Visit Notes __Visit Summary __Immunization Record __Medications __Labs __EKGs
__Chart Cover __School/Work Excuse __Other: _____

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 is specified, this authorization will expire ***one year*** from the signature date. I also understand that 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.***

Printed Name: _____ Relationship to Patient: _____

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

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 _x_Other (Please Specify):written and verbal communication
__Alcohol/Drug Treatment Records __Alcohol/Drug Assessments __Labs & Treatment Record

I understand that special permission must be given to release 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 will no longer 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:_____

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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: **Do you have insurance: Yes No (if no, sliding scale fee available)**

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

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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_____
_____

Developmental Milestones

At what age did your child: Crawl_____Walk_____Talk_____
Dress themselves_____Feed themselves_____
Does your child have any motor skill functioning issues? _____

CHILD'S PAST MEDICAL HISTORY

Previous Diagnosis and Dates of Diagnosis:

_____
_____
_____

Any Hospitalizations? (Including Psychiatric) ☐Yes ☐No

Reason for Hospitalization	Date of Hospitalization	Facility Where Hospitalized

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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 _____

_____

_____

_____