Confidential: Not to be Re-released without express written consent.

THIS FORM IS OPTIONAL YOU ARE NOT REQUIRED TO RELEASE

Bearden Behavioral Health

Primary Care Communication Form

Physician's Name _____Phone #_____ Fax#_____

Dear Dr. _____:

Your patient, _____, DOB _____, was seen by

_____, APN in our office. Date of initial assessment: _____

Most recent appointment: _____. Follow up in:_____

Diagnosis and/or presenting problem: _____

.

_____

_____

Treatment Recommendations: _____

_____

Medication (if applicable): _____

Please call if further information would be helpful. Sincerely,

_____ (865) 212 6600

Signature Phone

Authorization to Disclose Information

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.

Patient, please check one:

_____ I agree to release this information to my physician listed above.

_____ I do not agree to release this information to my physician listed above.

_____ I do not have a physician.

Patient Signature _____Date _____

Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Bearden Behavioral Health
Medication Flow Sheet

Patient Name:_____

Date of Birth:_____

Pharmacy Address:_____

Phone:_____

Fax:_____

Psych Medications:

Start Date	Stop Date	Drug Name (brand + generic)	Dosage	Frequency

Drug Allergies & Reactions:_____

_____

Informed Consent for Psychiatric Medications

Patient Name:
Patient Date of Birth:
Today's Date:
Practitioner Name: _____, APN
State License #:
Practice Location: Bearden Behavioral Health

My nurse practitioner (NP) and I discussed:

1. The nature of my mental condition.

2. My NP's reasons for prescribing the medication, including the likelihood of my condition improving or not improving without the medicine.

3. I can refuse to take any medication at any time, but it is recommended that I discuss my decision with my NP before I stop taking any medication.

4. Reasonable alternative treatments available for my condition.

5. The type of medication that I will be receiving, the frequency and range of dosages, the method by which I will take the medication, and the duration of such treatment.

6. The common side effects of this medication, and any particular side effects likely to affect me.

7. That certain antipsychotic medications may cause additional side effects for some persons, including tardive dyskinesia. Tardive dyskinesia is defined as persistent involuntary movements of the face, mouth, torso, hands, or feet. These symptoms are potentially irreversible, and may continue after the antipsychotic medication has been stopped.

8. **For Females**: Because certain medications could be harmful to a developing fetus, I will notify my NP immediately if I suspect pregnancy or have plans to attempt pregnancy

I was given information about the recommended medication. I understand that the information does not cover everything, but it includes items of clinical significance to me. I should discuss all my medical problems and any medication that I take with my NP/physician(s). For more information I may refer to a pharmacist or to a standard text such as the Physician's Desk Reference (PDR).

I have received the information about the psychotropic medication by means of: (Check those that apply)

☒ Oral Explanation ☒ Printed Material ☐ Video Presentation ☐ Other

Name of Medication (Generic name is acceptable. Include anticipated dosage range.):
_____

_____

I understand I have the right to refuse this medication, and that it cannot be given to me until I have spoken with my physician and given consent to it, except in an emergency. I understand and give consent to the medication listed above, which is an FDA approved medication, although its use in my condition(s) may not always appear as part of its approved labeling.

Client/Parent/Guardian signature _____Date _____

APN signature _____Date _____

Child/Adolescent Psychiatry Screen (CAPS)

Child's Name:_____Date of Birth :_____ Male _____ Female _____

Form Completed By:_____ Relationship to Child:_____

For each item below, check the one category that best describes your child ***during the past 6 months.***

None = the child never or very rarely exhibits this behavior. **Mild** = the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior. **Moderate** = the child exhibits this behavior at least three times per week, and others notice or comment on this behavior. **Severe** = the child exhibits this behavior almost daily, and multiple others complain about this behavior.

Past = the child used to have significant problems with this behavior, ***but not during the past 6 months.***

None Mild Moderate Severe *Past*

1. Has difficulty separating from parents* (* = or major caregiver/guardian) _____ _____ _____ _____ _____
2. Worries excessively about losing or harm occurring to parents _____ _____ _____ _____ _____
3. Worries about being separated from parent* (getting lost or kidnapped) _____ _____ _____ _____ _____
4. Resists going to school or elsewhere because of fears of separation _____ _____ _____ _____ _____
5. Resists being alone or without parents _____ _____ _____ _____ _____
6. Has difficulty going to sleep without parent nearby _____ _____ _____ _____ _____
7. Physical complaints (headache, stomach ache, nausea) when anticipating separation _____ _____ _____ _____ _____
8. Has discrete periods of intense fear that peak within 10 minutes _____ _____ _____ _____ _____
9. Has excessive, unreasonable fear of a specific object or situation _____ _____ _____ _____ _____
10. Has recurrent thoughts that cause marked distress (e.g., fears germs) _____ _____ _____ _____ _____
11. Driven to perform repetitive behaviors (e.g., handwashing, doing things 3 times) _____ _____ _____ _____ _____
12. Has recurrent, distressing recollections of past difficult or painful events _____ _____ _____ _____ _____
13. Worries excessively about multiple things (e.g., school, family, health, etc.) _____ _____ _____ _____ _____
14. Goes to the bathroom at inappropriate times or places _____ _____ _____ _____ _____
15. Makes noises, and is often unaware of them _____ _____ _____ _____ _____
16. Makes repetitive, sudden, nonrhythmic movements _____ _____ _____ _____ _____
17. Fails to pay close attention to details or makes careless mistakes _____ _____ _____ _____ _____
18. Has difficulty sustaining attention during play or school activities _____ _____ _____ _____ _____
19. Does not seem to listen when spoken to directly _____ _____ _____ _____ _____
20. Does not follow through on instructions; fails to finish schoolwork/chores _____ _____ _____ _____ _____

Child/Adolescent Psychiatry Screen (CAPS) - continued

None Mild Moderate Severe *Past*

21. Has difficulty organizing tasks and activities _____ _____ _____ _____ ____
22. Loses things necessary for tasks are activities (toys, pencils, etc.) _____ _____ _____ _____ ____
23. Is easily distracted easily by irrelevant stimuli _____ _____ _____ _____ ____
24. Is forgetful in daily activities _____ _____ _____ _____ ____
25. Is fidgety or squirms in seat _____ _____ _____ _____ ____
26. Has difficulty remaining seated _____ _____ _____ _____ ____
27. Runs or climbs excessively; is restless _____ _____ _____ _____ ____
28. Talks excessively _____ _____ _____ _____ ____
29. Blurts out answers before questions have been completed _____ _____ _____ _____ ____
30. Has difficulty waiting turn _____ _____ _____ _____ ____
31. Interrupts or intrude on others _____ _____ _____ _____ ____
32. Episodes of unusually elevated or irritable mood _____ _____ _____ _____ ____
33. During this episode, grandiosity or markedly inflated self-esteem (Superhero) _____ _____ _____ _____ ____
34. During this episode, is more talkative than usual/seems pressured to keep talking _____ _____ _____ _____ ____
35. During this episode, races from thought to thought _____ _____ _____ _____ ____
36. During this episode, is very distractible _____ _____ _____ _____ ____
37. During this episode, excessively involved in things (too religious, hypersexual) _____ _____ _____ _____ ____
38. During this episode, dangerous involvement in pleasurable activity (spending, sex) _____ _____ _____ _____ _____
39. Depressed or irritable mood most of the day, most days for at least 1 week _____ _____ _____ _____ _____
40. Loss of interest in previously enjoyable activities _____ _____ _____ _____ ____
41. Notable change in appetite (not when dieting or trying to gain weight) _____ _____ _____ _____ ____
42. Difficulty falling or staying asleep, or sleeping excessively through the day _____ _____ _____ _____ _____
43. Others notice child is sluggish or agitated most of the time _____ _____ _____ _____ ____
44. Loss of energy nearly every day _____ _____ _____ _____ ____
45. Feelings of worthlessness or inappropriate guilt nearly every day _____ _____ _____ _____ ____
46. Thinks about dying or wouldn't care if died _____ _____ _____ _____ ____
47. Smokes cigarettes, drinks alcohol, OR abuses drugs (Circle all that apply) _____ _____ _____ _____ _____
48. Has bad things happen when under the influence of substances _____ _____ _____ _____ ____

Child/Adolescent Psychiatry Screen (CAPS) - continued

None Mild Moderate Severe *Past*

49. Has made unsuccessful efforts to stop using a substance _____ _____ _____ _____ _____
50. Is excessively worried about gaining weight, even though underweight _____ _____ _____ _____ _____
51. If female, has stopped having menstrual cycles (after regularly having) _____ _____ _____ _____ _____
52. Thinks he/she is fat, even though not overweight (pulls skin and claims is fat, etc.) _____ _____ _____ _____ _____
53. Engages in binging and purging (eats excessively, then vomits or uses laxatives) _____ _____ _____ _____ _____
54. Bullies, threatens, or intimidates others _____ _____ _____ _____ _____
55. Initiates physical fights _____ _____ _____ _____ _____
56. Uses weapons that could harm others _____ _____ _____ _____ _____
57. Has been physically cruel to animals _____ _____ _____ _____ _____
58. Has shoplifted or stolen items _____ _____ _____ _____ _____
59. Has deliberately set fires _____ _____ _____ _____ _____
60. Has deliberately destroyed others' property _____ _____ _____ _____ _____
61. Lies to obtain goods or to avoid obligations _____ _____ _____ _____ _____
62. Stays out at night despite parental prohibitions _____ _____ _____ _____ _____
63. Has run away from home overnight on at least two occasions _____ _____ _____ _____ _____
64. Is truant from school _____ _____ _____ _____ _____
65. Loses temper _____ _____ _____ _____ _____
66. Actively defies or refuses to comply with adult rules _____ _____ _____ _____ _____
67. Deliberately annoys others _____ _____ _____ _____ _____
68. Blames others for his/her mistakes or misbehavior _____ _____ _____ _____ _____
69. Easily annoyed by others _____ _____ _____ _____ _____
70. Is spiteful or vindictive _____ _____ _____ _____ _____
71. Has unusual thoughts that others cannot understand or believe _____ _____ _____ _____ _____
72. Hears voices speaking to him/her that others don't hear _____ _____ _____ _____ _____
73. Does poorly at sports or games requiring physical coordination skills _____ _____ _____ _____ _____
74. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply) _____ _____ _____ _____ _____
75. Had delayed speech or has limited language now _____ _____ _____ _____ _____
76. Avoids eye contact during conversations _____ _____ _____ _____ _____

Child/Adolescent Psychiatry Screen (CAPS) - continued

None Mild Moderate Severe *Past*

77. Does not follow when others point to objects _____ _____ _____ _____ ____
78. Shows little interest in others; emotionally out of sync with others _____ _____ _____ _____ ____
79. Difficulty starting, stopping conversation; continues talking after others lose interest _____ _____ _____ _____ _____
80. Uses unusual phrases, possibly over and over (speaks Disney or movie lines) _____ _____ _____ _____ _____
81. Does not engage in make-believe play; plays more alone than with others _____ _____ _____ _____ _____
82. Unusual preoccupations with objects or unusual routines (lines up 100's of cars, etc.) _____ _____ _____ _____ _____
83. Difficulty with transitions; may be inflexible about adhering to routines or rules _____ _____ _____ _____ _____
84. Shows unusual physical mannerisms (hand-flapping, shrieks, objects in mouth, etc.) _____ _____ _____ _____ _____
85. Unusual preoccupations (schedules, own alphabet, weather reports, etc.) _____ _____ _____ _____ _____

Thank you for answering each of these items. Please list any other symptoms that concern you:

_____

_____

_____

_____

_____

_____

VITAL SIGNS (to be filled out by Office Staff)

Height

Weight

Blood Pressure

Pulse

Today's Date:_____

CSMD:_____

Completed by:_____