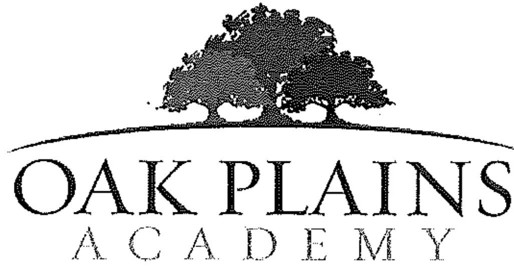


FACE SHEET

Please **PRINT** in all of the areas as ***thorough*** and ***legible*** as possible, using blue or black ink, **starting** with the youth's **Social Security Number** and ending with the **Education Section.** ******I have provided prompts for the areas where we typically have problems acquiring an entry.

Address This would be the office address of the FSW

MAR ST Single

Religion What is the youth's religion? If you're not sure simply line through this box or put NA please do not leave this blank

Race List the youth's applicable race

Advance Directive? Does the youth have one? Circle **Yes or No**

OCCUPATION Student

Resident's Legal Status US Citizen

Referral Source/Placing Agency: This is the **Placement Specialist** who sent the initial referral to Oak Plains Example; Ashley Barkley Smoky Mt Region. Please do not leave this section blank.

Guarantor Name: This is the Region the child's case is associated with (ie. Smoky Mt., Mid Cumberland etc) You can list your office address for the guarantor address.

Relationship/Agency DCS

SSN: line through this box or write NA

***** Please check the contract that has been agreed upon *****

Insurance information –Please provide the name of the insurance the youth has coverage through and ID number in this section.-**DO NOT** write **pending.** If you do not have this information upon intake leave this section blank, and provide a copy of the insurance card to the Admissions Office asap.

***********The Admissions Office will fill in the Admitting Diagnosis-IC09 Code, and Attending Physician***

Medical Information- List Allergies or Significant medical issues here or write or NA

Emergency Medical and Dental Contacts In the event of a medical emergency list person(s) other than the FSW whom we would need to notify or simply write NA

Education Type-Circle which applies (Regular or Special) –**Circle Grade and answer yes or no** for the IEP

For areas that don't pertain to you write NA or simply line through the box. Do NOT leave any of the above mention sections blank. Incomplete packets can cause a delay in the intake process.

Oak Plains Academy
FACE SHEET

Revised 10 /2017

A-100

RESIDENT INFORMATION

MED REC NUMBER:

THERAPIST:

EDP NUMBER	ADMIT DATE	ADMIT TIME	UNIT	TYPE	ADMITTING PHYSICIAN	SOC SEC NUMBER

RESIDENT NAME (LAST, FIRST, MIDDLE)	BIRTH DATE	AGE	SEX	MAR ST	RELIGION	RACE	ADVANCE DIR?
							YES or NO

ADDRESS	CITY	STATE	ZIP	COUNTY	PHONE

BIRTH STATE	OCCUPATION	RESIDENT'S LEGAL STATUS

EMERGENCY CONTACT/LEGAL GUARDIAN	EMER CONTACT ADDRESS	RELATIONSHIP	EMERGENCY PHONE

REFERRAL SOURCE/PLACING AGENCY	ADDRESS	TELEPHONE NUMBER

GRANTOR INFORMATION

GUARANTOR NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP/AGENCY	
	SSN:	

GUARANTOR ADDRESS	GUARANTOR CITY	STATE	ZIP	GUARANTOR PHONE

Contract Level

	L3 SED PRTF 1:8		L3 SED PRTF 1:1 HIGH
	L3 AS ND RTC 1:8		L3 AS ND PRTF 1:1 HIGH *(Neuro)*
	L3 AS ND PRTF 1:4 MID *(Neuro)*		RESPITE

INSURANCE INFORMATION

PRIMARY INSURANCE	CERT OR ID NUMBER	SECONDARY INSURANCE	CERT OR ID NUMBER
PRESCRIPTION CARD NUMBER			

ADMITTING DIAGNOSIS	ICD -10 CODE	ATTENDING PHYSICIAN

MEDICAL INFORMATION

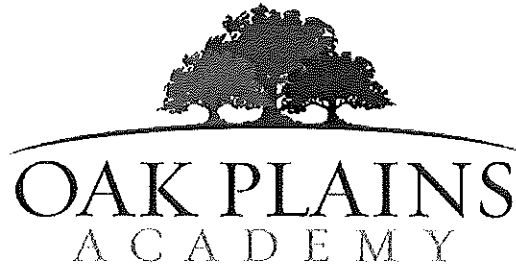
MEDICAL ALERT	EMERGENCY MEDICAL CONTACT	EMERGENCY DENTAL CONTACT
	Name:	Name:
	Number:	Number:
	Address:	Address:

EDUCATION

EDUCATION TYPE	GRADE	IEP
REGULAR or SPECIAL	1 2 3 4 5 6 7 8 9 10 11 12	YES or NO

DISCHARGE INFORMATION

DATE OF DISCHARGE		REASON FOR DISCHARGE	
DISCHARED TO		FORWARDING ADDRESS	



Authorization for Treatment for Emergency, Medical, and Psychiatric Care

Don't forget to initial what you are actually authorizing in the middle.

Please complete this form in its entirety, to include the resident's name and social security number. We CANNOT admit the resident if this form is not completed.

AUTHORIZATION FOR TREATMENT FOR EMERGENCY, MEDICAL, AND PSYCHIATRIC CARE

I, ______________________________, authorize the staff of Oak Plains Academy to
Guardian
provide my child/ward ____________________, Social Security Number ______________,
and any medical mental health, dental, vision, and ancillary services they deem necessary. If a physician's and/or nurse's judgment indicates a patient is in a need or emergency medical care, I understand that every reasonable effort will be made to notify the patient's parent, guardian or family member prior to treatment and/or transfer of patient and pertinent medical information to another facility. However, if the telephone, I understand that I will authorize the following:

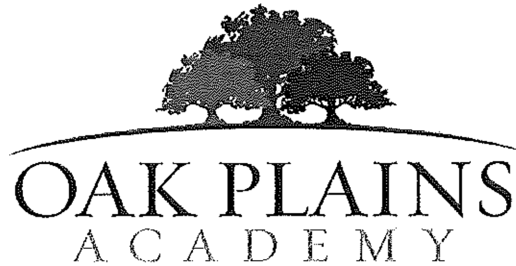
______Transfer of the patient to a facility better able and equipped to render the medical/emergency care needed.

______Release of pertinent medical records and information (written and/or verbal) to and from the facility providing medical emergency care and psychiatric care.

______________________________ ______________
Parent/Guardian Date

______________________________ ______________
Witness Date

Office of Admissions ~ 1751 Oak Plains Rd, Ashland City TN, 37015 ~ Phone: 931.362.4723 ~ fax: 931.362.2816



Consent for Treatment

Please read and INITIAL each section on this form.
Please no check marks or X's.

The FSW signs as the Parent/Guardian

Where it asked for Signature of Insured/Guarantor you can write the Region (i.e. Southwest, TN Valley) the child came into custody here.

Oak Plains Academy
Consent for Treatment

CONSENT FOR TREATMENT

I hereby authorize Oak Plains Academy, Its staff, and attending physicians to render treatment for
____________________, The undersigned authorizes:
Print Patients Full Name

_____Agrees that Oak Plains Academy will not be responsible for the safety or are of the resident if the resident leaves the premises and will indemnify Oak Plains Academy from any loss of injury which may occur as a result of leaving against medical advice.

_____Understand(s) that the use of Protective Hold and/or Escorts may be necessary, if severity of symptoms or behaviors warrant, In order to protect the resident from harming him/himself or others. I have received a copy of the Restraint Policy (Policy # PC.30)
______________________ (Resident Signature) Resident acknowledges receipt and understanding of Restraint Policy

_____Acknowledges that each resident is under control of an attending physician and Oak Plains Academy is not liable for any act or omission in following the instructions of said physician. The undersign recognizes that certain healthcare professionals furnishing service to the resident, including but not limited to, psychiatrists, psychologists, or other licensed healthcare providers may be independent contractors and not be employees or agents of Oak Plain Academy.

_____Understands that Oak Plains Academy reserves the right to request withdrawal of the resident from the program due to the following reasons: treatment resistance, falling to meet treatment goals, illegal behaviors such as bringing into the facility illegal substances, intentional behaviors to harm others.

_____Understands that Oak Plains Academy pursuant to State of Tennessee Statue is under is under a strict mandate to report any end all allegations of emotional, physical, and/or sexual abuse to Child Protective Services for investigation.

_____Understands that Oak Plains Academy has a responsibility to preserve a substance free treatment environment. Therefore, I permit Oak Plains Academy to collect urine samples and to conduct urinalysis when there reasonable suspicion that forbidden substances are present in the environment. I further understand that when there is reasonable suspicion, a urine sample may be collected following a therapeutic leave from the program.

_____Understands that Oak Plains Academy has the responsibility to preserve the safety and security of residents, employees, and visitors. All residents and their belongings are subject to search with reasonable cause. Therefore, I permit Oak Plains Academy to search belongings upon admission following a period away from the facility (TLOA, AWOL, recreational outings), and/or anytime there is suspicion of contraband in the environment.

_____Authorizes the facility to search the personal belongings of the resident when there is reason to believe that the resident may be or is in possession of an item or items, which may be dangerous to his/her health or the health of others. If any are found, it is understood that they will be maintained in a secure place and returned to the resident at discharge unless otherwise therapeutically indicated by the attending physician.

Oak Plains Academy
Consent for Treatment

______Releases Oak Plains Academy from any liability for the loss or damage of personal property and money kept in the resident's room during his/her treatment stay. Additionally the facility will not be liable for any items left at the facility.

_____Authorizes Oak Plains Academy to release all resident information, Including specific information regarding diagnostic treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being treated including treatment for Acquired Immune Deficiency Syndrome (AIDS), while at Oak Plains Academy, to any insurance company, and/or third party payers, or representatives providing coverage for this admission, or to any Oak Plains Academy representative including, but not limited to Oak Plains Academy employees, attending physicians, other healthcare professionals or organizations. This information may not be released to any other persons or entity unless the undersigned so authorizes.

______Acknowledge that such disclosures shall be limited to information that is reasonable and necessary for the discharge of the legal or contractual obligation of the person(s) or entities to which information is released. The undersigned further authorizes Oak Plains Academy to release information for the purpose of obtaining pre-authorization for treatment and concurrent review and to release that information to medical review agencies, and/or third party payers providing coverage or having responsibility for this admission.

_____Authorizes free exchange of medical record information, including but not limited to the release of resident information indicated above, between Oak Plains Academy and the attending physician, his/her group practice association and/or other healthcare agencies, facilities and/or professionals which may provide services to resident during this admission.

GUARANTEE OF PAYMENT

_____Hereby agree(s) to guarantee payment of the bill for services rendered by Oak Plains Academy. The undersigned agree(s) whether signing as guarantor or as a resident that in consideration of the services to be rendered to the resident, to be hereby jointly and individually obligated to pay the account of Oak Plains Academy in accordance with the regular rates and terms of Oak Plains Academy. Should the account be referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of the amount(s) not paid when due.

CONSENT FOR PHOTO/ACKNOWLEDGEMENT OF THE USE OF CAMERA

_____I authorize Oak Plains Academy to take a photograph to be maintained in the medical record and Medication Administration Record for the purpose of identification.

_____I acknowledge and understand that camera and surveillance equipment is utilized at Oak Plains Academy to ensure security and the safety of the residents, employees and visitors.

CONSENT FOR THERAPEUTIC TRIAL, VISITS, FIELD TRIPS, RELIGIOUS AND FACILITY ACTIVITIES.

Treatment for residents at Oak Plains Academy includes activities and field trips away from the facility, as well as therapeutic leaves. In order for us to provide these forms of treatment however, it is necessary that the resident and his or her parent/guardian agree to the terms set forth in the following paragraph:

Oak Plains Academy
Consent for Treatment

_____The undersigned herby acknowledge that the resident's attending physician may include in the treatment activities or field trips away from the facility, and the attending physician may at times allow the resident therapeutic trial visits away from the facility. In consideration of the value to the resident of such treatment, the undersigned hereby; (1) consents to the resident participation in the field trips, activities, and therapeutic trial visits: (2) releases Oak Plains Academy, its employees and its agents from all liability for any injury to the resident caused by an act or omission on their part in the course of such field trips, activities, and leaves; (3) agrees to indemnify and hold harmless the Oak Plains Academy, its medical staff, Its employees and its agents from all claims, costs and losses as a result of the act of the resident while on such field trips, activities and leaves.

______Oak Plains Academy believes in treating the whole patient. We recognize this is to include spiritual needs while in treatment. As part of the program the patient will have the opportunity to attend religious activities and services offered by the local community. The undersigned herby acknowledge consent for the Patient to participate in religious activities and services while in treatment at Oak Plains Academy.

RESPONSIBILITY FOR DESTRUCTION OF PROPERTY

_____Understands the resident is responsible for any damages to or destruction of Oak Plains Academy property belonging to others which may be located at Oak Plains academy. The undersigned agree to accept liability for, and reimburse Oak Plains Academy or other owners of, property, which the resident may damage or destroy.

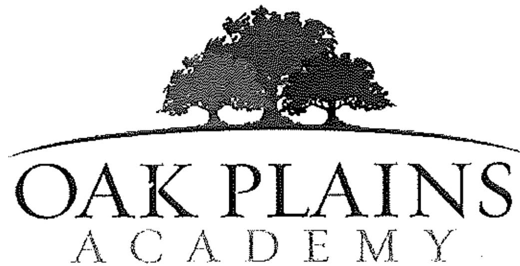
RESIDENT HANDBOOK AND RESIDENT/PARENT RIGHTS

_____I acknowledge that I received at the time of admission, with explanation, the program handbook and Resident's/Parents Rights. I understand and agree with the programs level system.

_____The Declaration of Mental Health has been made available to me.

_____I have received contact numbers for the Joint Commission, Tennessee Department of Mental health and Developmental Disabilities, and Disability law and Advocacy Center.

(Print) Name of Resident	Date
Signature of Parent/Guardian	Date
Signature of Insured/Guarantor	Date
Oak Plains Academy Staff Signature	Date



Medication Consent Form

Please list each **current** medication and the dosage. These are the medications that the youth is bringing with them to Oak Plains. Please do not submit form with signatures only.

ADMISSION MEDICATION CONSENT FORM

Please list all medications below with dosage and time to be administered. (Inform the admitting personnel if you need any additional consents.)

I, ______________________ do hereby give consent for Oak Plains Academy to continue
Parent/Guardian

the administration of the following Medications to ______________________.
Resident

Medication Name	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

I understand that any questions or concerns I may have regarding the above medications will be addressed by the Nursing Department upon admission.

______________________ Parent/Guardian ______________________ Date

______________________ Witness ______________________ Date

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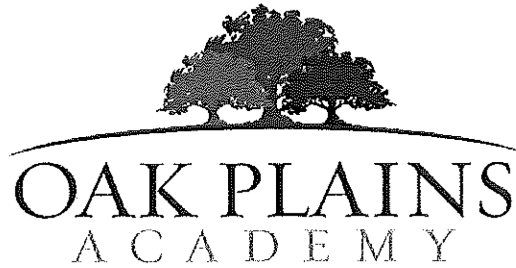
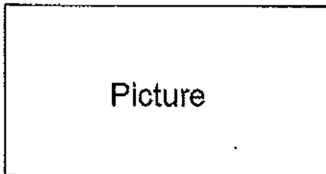


Emergency Contact Information

Please complete this form as thorough as possible. If the parents still have guardianship then their name(s) should be listed on this page as well.

Oak Plains Academy

Emergency Contact Information



Child's Name:______________________________DOB:_______________

In the event of an emergency the following need to be contacted:

Guardians Name:____

Guardians Phone Number(s):__________________________________

____

Guardians Address:____

Guardians relationship to child:______________________________

Guardians Name:____

Guardians Phone Number(s):__________________________________

____

Guardians Address:____

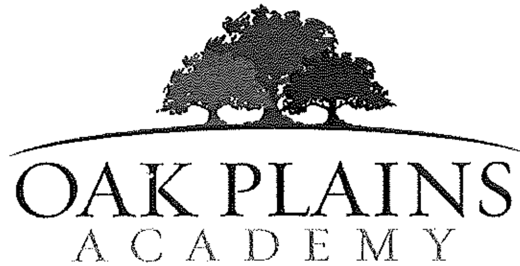
Guardians relationship to child:______________________________

DCS Caseworkers Name:_______________________________________

DCS Caseworkers Phone Number(s):__________________________

____

DCS Caseworker's County:____________________________



Approved Phone List for Resident/Approved Visiting and Mailing List for Resident

Please complete this form top and bottom do not put same as above and include mailing addresses. **Don't forget to sign the top and bottom.**

APPROVED PHONE LIST FOR RESIDENT

____
Resident

1. Name: __________ Relation: __________ Phone: __________
2. Name: __________ Relation: __________ Phone: __________
3. Name: __________ Relation: __________ Phone: __________
4. Name: __________ Relation: __________ Phone: __________
5. Name: __________ Relation: __________ Phone: __________
6. Name: __________ Relation: __________ Phone: __________

______________________________ ______________
Parent/Guardian Date

______________________________ ______________
Witness Date

APPROVED VISITING AND MAILING LIST FOR RESIDENT

Please initial if you allow written correspondence with those listed below

1. Name: __________ Relation: __________ Mail: __________
2. Name: __________ Relation: __________ Mail: __________
3. Name: __________ Relation: __________ Mail: __________
4. Name: __________ Relation: __________ Mail: __________
5. Name: __________ Relation: __________ Mail: __________
6. Name: __________ Relation: __________ Mail: __________

______________________________ ______________
Parent/Guardian Date

______________________________ ______________
Witness Date

1751 Oak Plains Rd, Ashland City TN, 37015 ~ Phone: 931.362.4723 ~ fax: 931.362.2816

Personal Safety Statement

As discussed, every youth in this program has certain rights but there is one right so important that we want to discuss it separately; that is your right over your own body. Only you have the right to decide who can or cannot touch you and want to help you protect that right.

If an adult or another young person tries to talk to you or touch you in any way that makes you feel uncomfortable, you have a right to put a stop to it. They may try to make excuses or even blame you for their actions but they are the ones who are wrong. It is never your fault.

We want to help you to be safe but we need your help. If someone does or says something that makes you feel uncomfortable, tell a MHA, Teacher, Nurse, or Therapist etc. It does not matter how long ago it happened, it is always best to tell someone that you trust. We understand that it is often hard to talk about these things, especially if you care about the person who mistreated you but your rights come first.

DISCLAIMER

I understand that I have a right over my own body and I have a right to personal safety.

______________________	______________
Youth	Date
______________________	______________
Witness	Date

Office of Admissions ~ 1751 Oak Plains Rd, Ashland City TN, 37015 ~ Phone: 931.362.4723 ~ fax: 931.362.2816

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTE: We are required by law to provide each patient a copy of out Notice of Privacy Practices, obtain an acknowledgement the Notice was provided, and keep the acknowledgement in out records. Also with the notice of Privacy Practices, you will be given a copy of this acknowledgement for your records.

ACKNOWLEDGEMENT OF RESIDENT

I acknowledge that on the date indicated below I was provided a paper copy of the Notice of Privacy Practices of Oak Plains Academy. I understand that this Notice describes how medical information about me may be used and disclosed and how I can get access to this information. I understand that I should review the Notice of Privacy Practices carefully.

Print Resident's Name	Resident's Signature	Date

ACKNOWLEDGEMENT OF PERSONAL REPRESENTATIVE

I acknowledge that on the date indicated below, I represented that I am the personal representative of the resident named below and that I was provided a paper copy of the Notice of Privacy Practices of Oak Plains Academy on behalf of this resident. I understand that this Notice describes how medical information about the patient may be used and disclosed and how I can get access to this information. I understand that I should review the Notice of Privacy Practices carefully.

Name of Personal representative (Print) (parent or guardian) ______ Signature of Personal Representative ______ Date ______

Name of Resident (Print) ______

()Parent/()Other (Explain) ______
Basis of Personal representative Status

(EDP#) RESIDENT IDENTIFICATION CODE ASSIGNMENT

EDP#	
Medic Medical Record Number	

Residents Name		**Admit Date**	

The four digit number assigned to the patient is for the security purposes and HIPPA privacy rules, the above number is to be kept confidential and used to access information regarding the resident care within out facility. As the parent of legal guardian it is your responsibility to inform all persons involved in the patient's care of this number (DHS, Parole Officer, Case worker, Attorney). As the legal guardian or parent of this resident I understand and agree to the conditions and security procedures of the EDP code. I have been informed by nursing staff or the treatment team member of the procedure and purpose of the EDP number. I understand that the facility will not release information without the EDP number regardless of involvement in the patient's treatment.

______________________ Legal Guardian/Parent

______________________ Nurse/Treatment Team Member

______________________ Date

______________________ Date

The EDP # along with proper instruction and information was given verbally via telephone to the Parent/Legal Guardian.

______________________ Nurse/Treatment Team Member

______________________ Date

______________________ Witness

______________________ Date

The nursing department attempted to contact the above named patients guardian to inform them of the EDP#. No contact was made; another attempt will be made at a later date.

______________________ Nurse

______________________ Date

______________________ Nurse

______________________ Date

______________________ Nurse

______________________ Date