Mike Boorn MR SIR2024-43 DOB: 12/02/1993 Male Anthem Blue Cross

Package: full chart

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Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Date 1st contact	Rep on intake call	1st contact name	1st contact phone	1st contact relationship
05/03/2024	Jennifer Rosa, Administrator	n/a	n/a	n/a

Location: Step Into Recovery Centers INC

Admission Date	Referrer	Contact?	Anticipated Discharge Date
05/03/2024 03:00 PM		No	

Discharge/Transition Date	Discharge/Transition to
05/06/2024 12:00 AM	

PARTICIPANT INFORMATION HAS NOT BEEN VALIDATED - PLEASE VALIDATE

participant Information

Mike Boorn

Current Address:
6901 Canby Ave
Reseda, CA 91335

Date of Birth: 12/02/1993 SSN:

Birth Sex: Male

Pronouns:

Preferred Language:

Marital Status:

Race:
Ethnicity:

Payment Method

Insurance

Insurance Information

Insurance	Policy No.	Effective Date	Termination Date	Status	Insurance Type/Priority
Anthem Blue Cross	NSA0555668gH			Active	

Internal ID / External ID	Group Plan Name	Group ID	Plan Type	Payor Type	Insurance Phone
126670034 /					

Rx Name	Rx Group	Rx BIN	Rx PCN	Rx Phone	Plan Period

Claims

Street Address 1	Street Address 2	Claims Fax

City	State	ZIP Code	Country

Subscriber	Relationship of Patient to Subscriber	SSN	DOB	Gender
Mike Boorn	Self		12/02/1993	Male

Subscriber Address Street	Subscriber Address Street 2	Subscriber City
6901 Canby Ave		Reseda

Subscriber Address Zip	Subscriber Address State	Subscriber Address Country
91335	CA	

Concurrent Reviews

Start Date	End Date	# of Days	Auth Date	Authorization Number		Status	Managed	Level of Care
05/03/2024						New	Yes	MH PHP

Next Review	Days of Week	Hours per Day	Days per Week	Frequency	LCD	Next LOC	Next LOC Date
				Daily	No		

Insurance Name	Insurance Policy No.
Anthem Blue Cross	NSA0555668gH

5/22-No VOB, no dx codes, no consent signed, no pre-admission assessment. Will begin auth once these are completed.

Contacts

Allergies and Food Restrictions

Allergies

No Known Allergies/NKA

Diets

Regular Diet

Lab Testing

Lab Bill To	Lab Guarantor Type	Lab Guarantor	Lab Guardian	Lab Patient Class
Unassigned	Unassigned	Unassigned	Unassigned	Not Applicable

Lab Primary Insurance	Lab Secondary Insurance
Unassigned	Unassigned

participant Record Source: N/A

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

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Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Pre-Admission Assessment 05/07/2024 12:06 PM

Date/Time of Assessment: 05/07/2024 12:06 PM

Race:

Marital Status:

Number of Marriages:

Living Arrangements

With whom does the patient live:

Does the patient wish to return to current living situation? ☐ Yes ☐ No

Does the client have children?

Are you pregnant?

Are you employed?

Does your employer know you are here?

If yes, when are you supposed to return to work?

Do you have any mobility issues/concerns?

Are you ambulatory?

Presenting Problem/Crisis/Precipitating Events leading to seeking treatment at this time:

Contributing Factors Leading to Seeking Treatment:

Outpatient Providers

	Name of Treating Providers	Phone Numbers and/or Locations	Last Visit (Month/Year)
Psychiatrist			
Therapist/Counselor			
PCP/Other Specialist			

Previous Substance Abuse/Psychiatric Treatments

Treatment History:

	Facility (include Location)	Treatment Dates	Level(s) of Care	Length of Treatment	Outcome	How long did they stay abstinent?

Medical History

Current Medical Conditions:

Current Medications:

	Medication	Prescribed for	Dosage & Frequency	Prescribed by	Last Visit	Compliant	Able to bring in?

Allergies:

No Known Allergies/NKA

Psychiatric Conditions:

Substance Abuse History

Substance History:

	First Used	Last Used	Frequency/Duration	Amount	Method	Pattern of Use (Episodic, Experimental, Binge, Continued)
Alcohol						
Marijuana						
Cocaine (Powder)						
Crack Cocaine						
Crystal Meth						
Heroin						

Suboxone/Zubsolv						
Oxycontin						
Methadone						
Other Opiates						
Benzodiazepines						
Hallucinagens						
Amphetamines						
Inhalants						
Ketamine (Special K)						
Triple C's						
Codeine						
Ecstasy						
Bath Salts						
Flakka						
MDMA/Molly						
Steroids						
K2Spice						
Kratom						
Kava						
Other OTC drugs						
Other						

Current Signs and Symptoms of Withdrawal

History of High Risk/Severe Withdrawal Symptoms:

Neurovegetative Signs and Symptoms

Sleep Patterns: Good ☐ Fair ☐ Poor ☐

Hours per Night:

Sleep Interruptions:

Appetite: Good ☐ Fair ☐ Poor ☐

Unanticipated weight gain?

Unanticipated weight loss?

	Yes	No
Loss or gain over the following time period?	☐	☐

Suicidal/Homicidal Lethality Risk Assessment

Suicidal Ideation:

How long has the client had these thoughts?

Does the Client have a plan?

Past history of suicide attempts?

How was the attempt made?

Homicidal Ideation?

History of Violent Behavior (describe)

Self Abuse History

Does patient have a history of self mutilation?

How and where does client typically disfigure him/herself?

Eating Disorders:

Preadmission Mental Status

Speech:

Judgment:

Insight:

Thought Process:

Memory:

Attention:

Affect:

Family History

Father:

Mother:

Siblings:

Spouse:

Children:

Other:

Rationale for Treatment
Admission:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Assignment of Benefits / Release of Medical Information

I hereby authorize and request that payment of benefits by my Insurance Company(s), Anthem Blue Cross, be made directly to Step Into Recovery Centers INC for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Step Into Recovery Centers INC to disclose any and all written information from the above named to my above named Insurance Company and/or its designated representatives, or other financially responsible parties; at the determination of Step Into Recovery Centers INC. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Step Into Recovery Centers INC and its officers, agents, employees, and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the above named Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless the above-named Insurance Company(s) or their designated representatives request records of information for reimbursement purposes, or seek to take action for the referred payment for treatment services.
- I agree to participate and assist Step Into Recovery Centers INC or its designated representatives with any appeal process necessary to collect payment for the services rendered.
- I am aware and have been advised of the provisions of Federal and State Statutes, rules, and regulations that provide for my right to the confidentiality of these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. In any event, this authorization will expire once reimbursement for services rendered is complete.
- Step Into Recovery Centers INC is acting in filing for insurance benefits assigned to Step Into Recovery Centers INC and it can assume no responsibility for guaranteeing payment of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by Step Into Recovery Centers INC for billing and collection purposes.
- Step Into Recovery Centers INC is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
- Step Into Recovery Centers INC shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Coordination of Benefits and Pre-existing Conditions

Date of Admission: 05/03/2024

This will confirm that upon admission to Step Into Recovery Centers INC, I, Mike Boorn:

☐ Have been employed for the past eighteen months and do not have Cobra coverage;

☐ Am presently unemployed, but did not work within the past eighteen months for the company identified below, but do not have Cobra coverage;

☐ Am presently employed with _____ (employer), but DO NOT have any hospital/medical/health insurance coverage;

☐ The only benefits available to me during my stay at Step Into Recovery Centers INC is from _____, (Name of Insurance);

☐ I have never been treated for this condition prior to my admission to Step Into Recovery Centers INC;

☐ Enrolled as a dependent of _____, who is my _____ (Relationship).

IN WITNESS WHEREOF I have here executed this agreement as dated below.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Activities Release and Waiver of Liability

Notice: This form contains a release and waiver of liability and when signed is a contract between the undersigned participant and Step Into Recovery Centers INC with legal consequences. Please read this Agreement, consisting of one (1) pages in its entirety, carefully before signing your name at the bottom of the page. This form must be signed in the presence of one (1) witness who should sign as a witness.

Date of Execution of Release and Waiver of Liability:

The undersigned agrees that this “Activities Release and Waiver of Liability” form agreement is valid from the date of execution through the date of discharge.

Acknowledgments and Representations by Client:

The undersigned is currently a client of Step Into Recovery Centers INC. The undersigned has voluntarily consented to participate in voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and other such types of voluntary sports or physical activities, which may not be specifically identified herein while being a client at such facility. The undersigned acknowledges and represents that their participation in such sports activities and physical activities is not a mandatory requirement of Step Into Recovery Centers INC, and that any participation by the undersigned in any and all sports-related activities and physical activities, is purely voluntary and of the undersigned’s own free will. The undersigned acknowledges and represents that there has been no coercion or force on the part of Step Into Recovery Centers INC for the undersigned to execute this release and waiver of liability agreement. The undersigned has knowingly, freely, and voluntarily consented to execute this release and waiver of liability agreement. The undersigned acknowledges and understands that it is the undersigned’s sole decision to participate in such voluntary activities. The undersigned acknowledges and represents that he has been informed that he has an absolute right to refuse to participate in any and all sports-related activities or physical activities.

To Step Into Recovery Centers INC, Inc.: In consideration of the opportunity afforded to me, by Step Into Recovery Centers INC, to participate in voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and any other similar types of voluntary sports or physical activities which may not be specifically identified herein, the undersigned client freely agrees to make the following contractual representations and agreements with Step Into Recovery Centers INC.

The undersigned client, does hereby knowingly, freely, and voluntarily assume all liability for any damage or injury that may occur as a result of my (or my dependent/ward) participation in the activities described herein and agree to release, waive, discharge, and covenant not to sue Step Into Recovery Centers INC, its officers, agents, employees, and volunteers from any and all liability or claims that may be sustained by me or a third party directly or indirectly in connection with, or arising out of participation in the activities described herein, whether caused in whole or in part by the negligence of Step Into Recovery Centers INC, or otherwise.

The undersigned client, has read this form, fully understand its terms, and understand that, I have given up substantial rights by signing it and have signed it freely and without any inducement or assurance of any nature and intend it to be a complete and unconditional release of any and all liability to the greatest extent allowed by law, and I agree that if any portion of this contract is held to be invalid the balance notwithstanding, shall continue in full legal force and effect.

I also agree, that the rules provided to me by the Step Into Recovery Centers INC, will be followed during the course of my voluntary participation in the activities described herein. Otherwise, my privilege of participating in such activities will be revoked immediately. Each client must sign a release and waiver of liability form in order to participate in the voluntary activities described herein. I acknowledge that due to the nature of the activities described herein, Step Into Recovery Centers INC staff will not be able to prevent injuries from occurring during the course of such activities; therefore, I am choosing to participate in such activities at my own risk and agree to assume all risks associated therewith.

Indemnification of Step Into Recovery Centers INC: The undersigned client shall at all times hereafter indemnify, hold harmless and, at Step Into Recovery Centers INC Attorney's option, defend or pay for an attorney selected by Step Into Recovery Centers INC to defend Step Into Recovery Centers INC, its officers, agents, servants, and employees against any and all claims, losses, liabilities, and expenditures of any kind, including attorney fees, court costs, and expenses, caused by negligent act or omission of the client, other clients, Step Into Recovery Centers INC, its employees, agents, servants, or officers, or accruing, resulting from, or related to the undersigned client engaging in any voluntary sports activities or voluntary physical activities such as volleyball, aerobics, and any other similar types of voluntary sports or physical activities which may not be specifically identified herein, including, without limitation, any and all claims, demands, or causes of action of any nature whatsoever resulting from injuries or damages sustained by any person or property. The provisions of this section shall survive the expiration or earlier termination of this Agreement or the discharge of the client from the residential/outpatient facility operated by Step Into Recovery Centers INC.

Venue: This Agreement shall be interpreted and constructed in accordance with and governed by the laws of the State of California Venue for litigation concerning this Agreement shall be in County.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Admission Orientation Checklist

Name: Mike Boorn MR#: SIR2024-43 DOB: 12/02/1993

Upon admission, I have been oriented and understand the following as indicated by a checkmark next to each requirement and my signature below.

- ☐ A description of services to be provided
- ☐ Consent for treatment
- ☐ A copy of the fee schedule, financial responsibility policy, and applicable fees
- ☐ Advanced Directives used at the facility
- ☐ A copy of individual rights
- ☐ A copy of the grievance process and procedure
- ☐ Program rules
- ☐ Group Confidentiality, Confidentiality and limitations of confidentiality
- ☐ Infection control procedures
- ☐ Therapist Assignment
- ☐ Treatment Schedule
- ☐ Fire exits and emergency evacuations procedures
- ☐ Emergency Services
- ☐ Responsibilities for participation in treatment
- ☐ A summary of the facility's admission and discharge criteria

My signature confirms that I have engaged in an orientation process with Step Into Recovery Centers INC staff member. It further confirms that I was given the opportunity to ask questions for clarification purposes and that I understand the aspects of the program listed above.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

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Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
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Step Into Recovery Centers INC

Client Rights

All individuals who apply for services, regardless of sex, race, age, color, creed, financial status, or national origin, are assured that their lawful rights as Clients shall be guaranteed and protected. While being served, you the Client are assured and guaranteed the following rights:

1. To be treated with respect and dignity.

2. To receive timely treatment by qualified professionals.

   a. Every effort will be made to use the least restrictive, most appropriate treatment available, based on Client needs.
   b. Each Client shall be afforded the opportunity to participate in activities designed to enhance self-image.
   c. An individualized treatment plan shall be developed for each Client in accordance with the provisions established for each program component.

3. To receive quality treatment that is best suited to his/her needs and shall include appropriate services, whether they be medical, vocational, social, educational, and/or rehabilitative services.

4. To express by signature an informed consent of the right to release information for communication purposes with other agencies.

5. To receive communication and correspondence from individuals.

6. To privacy for interview/counseling sessions.

7. To practice your religious practices.

8. To be provided humane care and protection from harm.

9. To contract and consult with legal counsel and private practitioners of your choice at your expense.

10. To exercise your constitutional, statutory, and civil rights.

11. To be free of physical restraint or seclusion.

12. To be informed of the nature of treatment or rehabilitation, the known effects of receiving the treatment or rehabilitation, and alternative treatment or rehabilitation programs.

13. To be provided with information on an ongoing basis regarding your treatment or rehabilitation.

14. To be provided services in accordance with standards of practice, appropriate to your needs, and designed to afford you a reasonable opportunity to improve your condition.

15. To confidentiality of the Client being in treatment and of the Client's records. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse Client. Federal regulations state any person who violates any provision of the law shall be fined not more than $500.00 in the case of the first offense and not more than $5,000.00 in the case of each subsequent offense, except where noted in the Federal Law of Confidentiality, 42 CFR, Part 2, Section 2.22, which includes the following:

a. The limited circumstances of release of Client information include, crimes on program premises or against program personnel, medical emergencies, mandated reports of child abuse or neglect, elderly abuse, threats to harm self or others, research, audit, and evaluations, or court orders.

16. To receive full information regarding the treatment process.

17. To refuse treatment.

18. To all other constitutional and legal rights, including the right to personal clothing and effects.

19. To be informed of the Client grievance procedure upon request.

Confidentiality of Alcohol and Drug Abuse Patient Records/Limits to Confidentiality

The confidentiality of alcohol and drug abuse Client records maintained by this program are protected by Federal law and regulations. Generally, the program may not say to a person outside the program that the Client attends the program or disclose any information identifying a client as an alcohol or drug abuser unless:

1. The Client consents in writing
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel
4. The disclosure to a qualified person for research, audit, or program evaluation; or
5. The disclosure is made to protect self or others or a crime has been committed; or
6. The disclosure in the event of threats of harm to self or others (Duty To Warn).

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by the Client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about elderly abuse, suspected child abuse or neglect, threats to harm to self or others from being protected. These may be released under State law to appropriate State or local authorities beyond Federal CFR42-Regulations.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations,)

Grievance Procedure:

1. Any person(s) who believes that their rights have been violated or has a complaint or grievance may file a complaint pursuant to the procedures set forth below, on their behalf or on the behalf of another person. All persons are encouraged to file a grievance. By filing a complaint the individual will not subject themselves to any form of adverse action, reprimand, retaliation, or otherwise negative treatment by Step Into Recovery Centers INC. The client shall have immediate access to the grievance form; a posting of the grievance procedure will be within the facility with the levels of appeals, and in the Patient Handbook.

2. The processing procedures for grievances and complaints are as follows:

a. The Client is encouraged to discuss any problems with their therapist. The Client and therapist will try to find a resolution. The therapist will correspond with the Clinical Director on the grievance and/or complaint and any resolution.
b. All grievances shall first be filed with the Clinical Director by completing a "Client Grievance" form. The Human Resources Director and/or Designee shall give the Client a receipt of the filed grievance and log the grievance. The Director will conduct an internal investigation and render an initial determination and resolution within 2 days of receipt of the complaint in writing.
c. If the complaint is not satisfied or if the complaint is not resolved with the results achieved in Step 2, the complaint may file an appeal and/or the grievance shall be forwarded to the Executive Director and this meeting shall be held within five working days of the date it is requested.
d. The Client shall be presented with a resolution and response to their grievance in writing.
e. In the event that the Client does not feel a resolution has been reached they may contact the state regulatory department and the applicable client advocacy institution.

3. The Clinical Director and the Executive Director shall take steps to ensure an appropriate investigation of each complaint to determine its validity. These rules contemplate informally, but thorough, investigations affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint.

4. Any allegations of physical or sexual abuse by a therapist shall immediately be brought to the attention of the Clinical Director and the police shall be notified. The Client will be afforded the opportunity to contact the Police, state Abuse Hotline, the state department of family services, and the state disability rights department where applicable. The telephone numbers of the hotlines are posted within the facility.

I, Mike Boorn, hereby acknowledge receipt of and understand the "Client Rights" statement.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Confidentiality Policy

The following information is provided to assist you in your counseling experience at Step Into Recovery Centers INC.

Counseling and treatment is a personal and confidential relationship between a clinician and individual, group, or family.

We work from a team approach at Step Into Recovery Centers INC. Therefore, there may be times when it is necessary for us to consult with other professional staff either individually or at our clinical team meetings in an effort to provide you with the highest consideration and quality. Our clinicians are all Mastered prepared and professionally licensed, graduate student interns, or clinicians working toward certification in substance abuse counseling.

No information will be released from Step Into Recovery Centers INC regarding counseling or consultation sessions without your expressed written consent. If you wish for information to be released to anyone, it will be necessary for you to complete a Release of Information form, stipulating the professional to whom the information is being sent. The law stipulates that in the event of imminent danger to yourself or others, we **must** breach confidentiality. We must also act in accordance with any applicable state laws regarding mandatory disclosure of child, elder, or other abuse.

I have read the above policies and procedures and understand them.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Consent for Reporting Communicable Diseases

I hereby give my permission to release to the California Public Health Department, Disease Control Division any information regarding the below:

California Statutes provide that any attending practitioner licensed in Florida to practice medicine who diagnoses or suspects the existence of a communicable disease among humans or from animals to humans shall immediately report that fact to the Department of Public Health.

The Public Health Unit serves as the department's representative in this reporting requirement.

Modifiable diseases or conditions which are to be reported**immediately** to the County Health unit are listed below:

- Outbreaks of any disease, any case, cluster of cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting (e.g., hospital, school, other institution) not listed that is of urgent public health significance

- Anthrax
- Amebic encephalitis
- Arboviral diseases not otherwise listed
- Botulism, foodborne, wound, and unspecified
- Brucellosis
- Chikungunya fever, locally acquired
- Cholera (*Vibrio cholerae* type O1)
- Dengue fever
- Diphtheria
- Glanders
- *Haemophilus influenzae* invasive disease in children <5 years old
- Hantavirus infection
- Hemolytic uremic syndrome (HUS)
- Hepatitis A
- Herpes B virus, possible exposure
- Influenza A, novel or pandemic strains
- Influenza-associated pediatric mortality in children <18 years old
- Listeriosis
- Measles (rubeola)
- Melioidosis
- Meningococcal disease
- Neurotoxic shellfish poisoning
- Paratyphoid fever (*Salmonella* serotypes Paratyphi A, Paratyphi B, and Paratyphi C)
- Pertussis
- Plague
- Poliomyelitis
- Rabies, animal or human
- Rabies, possible exposure
- Ricin toxin poisoning
- Rubella
- Severe acute respiratory disease syndrome (SARS) associated with coronavirus infection
- Smallpox
- Staphylococcal enterotoxin B poisoning
- *Staphylococcus aureus* infection, intermediate or full resistance to vancomycin (VISA, VRSA)
- Syphilis in pregnant women and neonates
- Tularemia
- Typhoid fever (*Salmonella* serotype Typhi)
- Typhus fever, epidemic
- Vaccinia disease
- Venezuelan equine encephalitis
- Viral hemorrhagic fevers
- Yellow fever
- Zika fever

Other:

Modifiable diseases or conditions which are to be reported within**48 hours** to the County Health unit are listed below:

- Acquired immune deficiency syndrome (AIDS)
- Arsenic poisoning
- Babesiosis
- Botulism, infant
- California serogroup virus disease
- Campylobacteriosis
- Cancer, excluding non-melanoma skin cancer and including benign and borderline intracranial and CNS tumors
- Carbon monoxide poisoning
- Chancroid
- Chikungunya fever
- Chlamydia
- Ciguatera fish poisoning
- Congenital anomalies
- Conjunctivitis in neonates <14 days old
- Creutzfeldt-Jakob disease (CJD)
- Cryptosporidiosis
- Cyclosporiasis
- Eastern equine encephalitis
- Ehrlichiosis/anaplasmosis
- *Escherichia coli* infection, Shiga toxin-producing
- Giardiasis, acute
- Gonorrhea
- Granuloma inguinale
- Hansen's disease (leprosy)
- Hepatitis B, C, D, E, and G
- Hepatitis B surface antigen in pregnant women and children <2 years old
- Herpes simplex virus (HSV) in infants <60 days old with disseminated infection and liver involvement; encephalitis; and infections limited to skin, eyes, and mouth; anogenital HSV in children <12 years old
- Human immunodeficiency virus (HIV) infection
- HIV-exposed infants <18 months old born to an HIV-infected woman
- Human papillomavirus (HPV)-associated laryngeal papillomas or recurrent respiratory papillomatosis in children <6 years old; anogenital papillomas in children ≤12 years old
- Lead poisoning (blood lead level ≥5 µg/dL)
- Legionellosis
- Leptospirosis
- Lyme disease
- Lymphogranuloma venereum (LGV)
- Malaria
- Meningitis, bacterial or mycotic
- Mercury poisoning
- Mumps
- Neonatal abstinence syndrome (NAS)
- Pesticide-related illness and injury, acute
- Psittacosis (ornithosis)
- Q Fever
- Rocky Mountain spotted fever and other spotted fever rickettsioses
- St. Louis encephalitis
- Salmonellosis
- Saxitoxin poisoning (paralytic shellfish poisoning)
- Shigellosis
- *Streptococcus pneumoniae* invasive disease in children <6 years old
- Syphilis
- Tetanus
- Trichinellosis (trichinosis)
- Tuberculosis (TB)
- Varicella (chickenpox)
- Vibriosis (infections of *Vibrio* species and closely related organisms, excluding *Vibrio cholerae* type O1)
- West Nile virus disease

Other:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Consent for Treatment

I authorize Step Into Recovery Centers INC to perform all clinical services deemed necessary in the evaluation of program/client appropriateness.

I have been advised and understand that Step Into Recovery Centers INC adheres to all Federal Laws of confidentiality and any suspected violations of the law must and will be reported.

I give my consent for the duration of my treatment and 90 days after discharge for Step Into Recovery Centers INC to release information regarding my progress and location in treatment to Referring Agencies, Probation, and Officers of the Court for the purpose of assuring my compliance with an order for treatment (if requested).

I agree to submit a urine/take an alcohol test, if requested, for drug testing. I understand that failure to do so could result in negative termination. Urine/alcohol results may be utilized as treatment interventions or may be completed as determined by external requirements.

I understand that I am responsible for all fees for the duration of my program.

I understand that if I fail to follow any communicable-disease-related referrals, Step Into Recovery Centers INC will need to report such to the County Health Department.

In case of a severe medical emergency, I have listed an emergency medical contact on a release form and do authorize Step Into Recovery Centers INC to contact that party should such an emergency occur.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Drug and Alcohol Use Policy

I, Mike Boorn hereby agree to participate fully in all aspects of my treatment while at Step Into Recovery Centers INC.

I understand that while I am in treatment at Step Into Recovery Centers INC, I am expected to:

Please initial the following statements:

- ☐ I understand that if I am prescribed any medication by any provider, I am expected to inform my attending clinician immediately.
- ☐ Abstain from the use of all illegal/non-prescribed substances and alcohol.
- ☐ I understand that frequent and random urinalysis and random breathalyzers are part of substance abuse treatment.
- ☐ I agree to provide a urine sample and/or breathalyzer upon request.
- ☐ I understand the refusal to provide a urinalysis or a breathalyzer when requested will be considered positive and may lead to discharge from the program.
- ☐ I understand that absolutely no alcohol, drugs, or drug paraphernalia is permitted on the premises. I understand that anyone suspected of being under the influence of drugs or alcohol or who possesses any illicit drugs or alcohol may be required to leave the program immediately.
- ☐ I understand that I cannot wear any clothing that glorifies or endorses the use of alcohol or drugs.

The above conditions have been explained to me and I fully understand my obligations while in treatment at Step Into Recovery Centers INC and agree to abide by the conditions stated above.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Group Confidentiality

To reinforce the feelings of closeness and willingness to share with others your feelings, thoughts, and consequences of your dependency, confidentiality is a must in group therapy. Use this as your golden rule: **What is said in Group, stays in Group** To break this rule violates the trust of the total group and the effectiveness of group therapy is lost.

The following guidelines will help you maintain this rule:

1. Group issues are not discussed with others outside your group.
2. Do not discuss group issues with your roommate unless he/she is in your group.
3. Do not discuss at any outside meetings or places where others may overhear you.

Your group therapists have the same responsibilities for group confidentiality as you, with the exception that your therapists share group issues and your participation in the group process with other staff members. This is a vital part of the staff team's approach to assist you in your recovery.

The staff values your confidentiality so highly that anyone who breaks confidentiality - whether to another patient of Step Into Recovery Centers INC or to family, significant others, etc., may be subject to discharge from this program.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Liability Waiver for Gym, Pool, and Sporting Events

The undersigned and the undersigned's heirs, executors, and administrators hereby waive and forever release and discharge Step Into Recovery Centers INC, its owners, staff, and sponsors of and from any and all claims, suits, or rights for damages for personal property damage and/or physical injury which may be sustained or which occurs during participation in physical and/or recreational activities at either the gym or the pool utilized by or at Step Into Recovery Centers INC that may occur to or from the physical and/or recreational activity, whether or not such injury or property damage or loss is caused by, is connected to, or arises out of any acts or omissions or the negligence of Step Into Recovery Centers INC, its owners, staff, and sponsors.

According to Federal Regulations for Client Confidentiality and Protected Health Information, I agree not to disclose to any and all persons while at the gym that I am a client of Step Into Recovery Centers INC, about my own or others' purpose for being at and/or participating in any and all activities.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the

purpose of payment or our operations with your health insurer.

- We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone’s health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: October 11, 2013

This Notice of Privacy Practices applies to the following organizations.

Step Into Recovery Centers INC

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Program Rules

1. The use of alcohol or other drugs is grounds for immediate discharge from the program.
2. Possession of weapons, sharp objects, acts of violence, or threats of violence are grounds for immediate discharge.
3. Smoking, vaping, or the use of smokeless tobacco products are allowed in designated outside areas only.
4. All Clients must sign out and in whenever they leave or return, as well as their destination.
5. Clients must attend all treatment activities unless excused by staff.
6. If you drive your car to the facility, keys must be turned into and kept by staff at all times. The use of your vehicle is by staff permission only.
7. Negative contracts involving major rule violations not reported to staff will result in consequences or discharge.
8. Clients will respect the personal property of other Clients and staff. Clients will not borrow the property of others.
9. Clients are responsible for their behavior and are expected to communicate, cooperate, and show respect to other Clients and staff.
10. Failure to abide by the rules may result in the restriction of privileges. In more serious cases, repeated violations, or disregard for program rules will result in an administrative discharge.
11. Being on time for all scheduled activities is required.
12. All treatment assignments are to be completed in a timely manner.
13. All assigned work responsibilities must be completed.
14. When you do not know what to do, do not assume…..ask the staff.
15. No profanity or verbal abuse of staff or other Clients is allowed.
16. Gambling is not permitted.
17. Logos on clothing that are explicit, gang, or drug-related are not permitted.
18. No tank tops, halter-tops, backless or low-cut clothing. No short shorts or other tight clothing is permitted.
19. Undergarments must be worn at all times.
20. No cameras, tape recorders, or other recording devices are permitted.
21. No material other than recovery related material.
22. Knowledge and awareness of all rules are expected.
23. All passes and clinical visits must be approved by the clinical staff and the Clinical Director.
24. All pass requests must be turned in weekly to the designated staff member each week.
25. No perfumes or any glass bottles are permitted.
26. No straight edge razors are permitted, electric razors are permitted.

27. No alcohol-based hand sanitizers are permitted.
28. No stuffed animals are permitted.
29. No safety pins or knives are permitted.
30. No mouthwash with alcohol is permitted.
31. I understand that if I am suspected of using alcohol/drugs, I will be asked to undergo a blood and/or urine test. If the results are positive, I may be asked to leave the program with an appropriate referral.
32. I am aware that regular attendance is a requirement of the program; I understand that breaking this rule can result in discharge from the program.
33. I understand that information discussed in groups is confidential and should not be discussed outside of the program.

Behavior that undermines treatment rules and expectations will not be tolerated. Violation of these rules will result in consequences and may result in dismissal from the program. Illegal activity is subject to criminal prosecution.

Step Into Recovery Centers INC rules have been explained to me so that I understand them and I have received a copy of these rules.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Uses and Disclosure of Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This notice is effective as of April 15, 2003

USES AND DISCLOSURE OF HEALTH INFORMATION

Step Into Recovery Centers INC is committed to protecting the privacy of the personal and health information we collect or create as part of providing health care services to our clients, known as “Protected Health Information” or “PHI”. PHI typically includes your name, address, date of birth, billing arrangements, care, and other information that relates to your health, health care provided to you, or payment for the health care provided to you. PHI DOES NOT include information that is de-identified or cannot be linked to you.

This notice of Health Information Privacy Practices (the “Notice”) describes Step Into Recovery Centers INC’s duties with respect to the privacy of PHI, Step Into Recovery Centers INC’s use of and disclosure of PHI, client rights, and contact information for comments, questions, and complaints.

Step Into Recovery Centers INC’S PRIVACY PROCEDURES AND LEGAL OBLIGATIONS

Step Into Recovery Centers INC obtains most of its PHI directly from you, through care applications, assessments, and direct questions. We may collect additional personal information depending upon the nature of your needs and consent to make additional referrals and inquiries. We may also obtain PHI from community health care agencies, other governmental agencies, or health care providers as we set up your service arrangements.

Step Into Recovery Centers INC is required by law to provide you with this notice and to abide by the terms of the Notice currently in effect. Step Into Recovery Centers INC reserves the right to amend this Notice at any time to reflect changes in our

privacy practices. Any such changes will be applicable to and effective for all PHI that we maintain including PHI we created or received prior to the effective date of the revised notice. Any revised notice will be mailed to you or provided upon request.

Step Into Recovery Centers INC is required by law to maintain the privacy of PHI. Step Into Recovery Centers INC will comply with federal law and will comply with any state law that further limits or restricts the uses and disclosures discussed below. In order to comply with these state and federal laws, Step Into Recovery Centers INC has adopted policies and procedures that require its employees to obtain, maintain, use and disclose PHI in a manner that protects client privacy.

USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as outlined below, Step Into Recovery Centers INC will not use or disclose your PHI without your written authorization. The authorization form is available from Step Into Recovery Centers INC (at the address and phone number below). You have the right to revoke your authorization at any time, except to the extent that Step Into Recovery Centers INC has taken action in reliance on the authorization.

The law permits Step Into Recovery Centers INC to use and disclose your PHI for the following reasons without your authorization:

For Your Treatment: We may use or disclose your PHI to physicians, psychologists, nurses and other authorized healthcare professionals who need your PHI in order to conduct an examination, prescribe medication, or otherwise provide health care services to you.

To Obtain Payment: We may use or disclose your PHI to insurance companies, government agencies, or health plans to assist us in getting paid for our services. For example, we may release information such as dates of treatment to an insurance company in order to obtain payment.

For Our Health Care Operations: We may use or disclose your PHI in the course of activities necessary to support our health care operations such as performing quality checks on your employee services. We may also disclose PHI to other persons not in Step Into Recovery Centers INC's workforce or to companies who help us perform our health services (referred to as "Business Associates") we require these business associates to appropriately protect the privacy of your information.

As Permitted or Required By The Law: In some cases, we are required by law to disclose PHI. Such as disclosers may be required by statute, regulation court order, government agency, we reasonably believe an individual to be a victim of abuse, neglect, or domestic violence: for judicial and administrative proceedings and enforcement purposes.

For Public Health Activities: We may disclose your PHI for public health purposes such as reporting communicable disease results to public health departments as required by law or when required for law enforcement purposes.

For Health Oversight Activities: We may disclose your PHI in connection with governmental oversight, such as for licensure, auditing, and the administration of government benefits.

To Avert Serious Threat to Health and Safety: We may disclose PHI if we believe in good faith that doing so will prevent or lessen a serious or imminent threat to the health and safety of a person or the public.

Disclosures of Health-Related Benefits or Services: Sometimes we may want to contact you regarding service reminders, health-related products or services that may be of interest to you, such as health care providers or settings of care or to tell you about other health-related products or services offered at Step Into Recovery Centers INC. You have the right not to accept such information.

Incidental Uses and Disclosures: Incidental uses and disclosures of PHI are those that cannot be reasonably prevented are limited in nature and that occur as a by-product of a permitted use or disclosure. Such incidental uses and disclosures are permitted as long as Step Into Recovery Centers INC use reasonable safeguards and use or disclose only the minimum amount of PHI necessary.

To Personal Representatives: We may disclose PHI to a person designated by you to act on your behalf and make decisions about your care in accordance with state law. We will act according to your written instructions in your chart and our ability to verify the identity of anyone claiming to be your personal representative.

To Family and Friends: We may disclose PHI to persons that you indicate are involved in your care or the payment of care. These disclosures may occur when you are not present, as long as you agree and do not express an objection. These disclosures may also occur if you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other person that may be involved in caring for you. You have the right to limit or stop these disclosures.

YOUR RIGHTS CONCERNING PRIVACY

Access to Certain Records: You have the right to inspect and copy your PHI in a designated record set except where State law may prohibit client access. A designated record set contains medical and billing and case management information. If we do not have your PHI recordset but know who does, we will inform you how to get it. If our PHI is a copy of the information maintained by another health care provider, we may direct you to request the PHI from them. If Step Into Recovery Centers INC produces copies for you, we may charge you up to $1.00 per page up to a maximum fee of $50.00. Should we deny your request for access to the information contained in your designated record set, you have the right to ask for the denial to be reviewed by another healthcare professional designated by Step Into Recovery Centers INC.

Amendments to Certain Records: You have the right to request certain amendments to your PHI if, for example, you believe

a mistake has been made or a vital piece of information is missing. Step Into Recovery Centers INC is not required to make the requested amendments and will inform you in writing of our response to your request.

Accounting of Disclosures: You have the right to receive an accounting of disclosures of your PHI that were made by Step Into Recovery Centers INC for a period of six (6) years prior to the date of your written request. This accounting does not include for purposes of treatment, payment, health care operations, or certain other excluded purposes, but includes other types of disclosures, including disclosures for public health purposes or in response to a subpoena or court order.

Restrictions: You have the right to request that we agree to restrictions on certain uses and disclosures of your PHI, but we are not required to agree to your request. You cannot place limits on uses and disclosures that we are legally required or allowed to make.

Revoke Authorizations: You have the right to revoke any authorizations you have provided, except to the extent that Step Into Recovery Centers INC has already relied upon the prior authorization.

Delivery by Alternate Means or Alternate Address: You have the right to request that we send your PHI by alternate means or to an alternate address.

Complaints & How to contact us: If you believe your privacy rights have been violated, you have the right to file a complaint by contacting Step Into Recovery Centers INC at the address and/or phone number indicated below. You also have the right to file a complaint with the Secretary of the United States Department of Health and Human Services in Washington, D.C. Step Into Recovery Centers INC will not retaliate against you for filing a complaint.

If you believe your privacy rights have been violated, you may make a complaint by contacting_____, HIPAA Privacy Officer at (___) ___-____ or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

The U.S.Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll-Free: 1-877-696-6775

RESTRICTION REQUEST:

I request a restriction on the Use or Disclosure of my following information:

CLIENT TO BE GIVEN A COPY ALONG WITH A COPY TO FILED IN CLIENT CHART

I acknowledge that I have received a copy of this notice regarding the use and disclosure of my health information.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Safety Contract

I, Mike Boorn, understand and agree to comply with the following recommendations. I understand that this contract has been created for my safety and well-being. By signing this contract, I agree to the following:

- I will take my medication as prescribed.
- I will inform an appropriate professional to call 911 (or transport me to the hospital) if I am in crisis.
- I will go to an appropriate professional to discuss any dangerous thoughts or feelings; such as suicidal ideations or thoughts of self-harm.
- At this time, I do not have any suicidal or homicidal thoughts or plans and my safety needs are being met.
- I am committed to leading a healthy lifestyle and recognize that I am a valuable and worthwhile person.
- I am committing myself to honor this contract for the remainder of my time in this program.
- I understand that my emergency contact will be called in the event that I need to be safely transitioned to a facility that is more appropriate to handle my mental health needs.

I understand that if I do not comply with these requirements, I will be referred to a facility that will appropriately meet my mental health needs.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Transportation Release and Waiver of Liability

Notice: This form contains a release and waiver of liability and when signed is a contract between the undersigned Client and Step Into Recovery Centers INC with legal consequences. Please read this agreement in its entirety carefully before signing your name. This form must be signed in the presence of a witness who will sign as a witness.

Client's Information:

Activities: This includes, but is not limited to Transportation to the facility from the Client's residence, from the facility to the Client's residence, medication pick-up, and transportation to the nearest mental health Receiving Facility.

Date of execution of Release and Waiver of Liability: . The undersigned agrees that this Release and Waiver of Liability Agreement is valid from the date of execution through the date of discharge from Step Into Recovery Centers INC.

Name of Facility: Step Into Recovery Centers INC

Client's Full Name: Mike Boorn

Parent/Guardian's Full Name:

Client/Parent/Guardian Phone Number:

Name and telephone number of emergency contact:

Acknowledgments and Representations by Client:

The undersigned Client, Mike Boorn, is currently a client at the Partial Hospitalization or Intensive Outpatient Program operated by Step Into Recovery Centers INC. This Client will be participating in the Transportation Services provided by Step Into Recovery Centers INC. This includes, but is not limited to Transportation to the facility from the Client's residence, from the

facility to the Client's residence, medication pick-up, emergency medical care, and transportation to the nearest mental health Receiving Facility.

The undersigned client, Mike Boorn (or parent/guardian of the individual named herein), does knowingly, freely, and voluntarily assume all liability for any and all damage or injury that may occur as a result of his/her (or his/her dependent's/ward's) participation in the activities described herein and agrees to **release, waive, discharge, and covenant not to bring suit against Step Into Recovery Centers INC,** its officers, agents, employees, and volunteers from/for any and all liability or claims that may be sustained by me or by a third party, directly or indirectly, in connection with or arising out of his/her (or his/her dependent's/ward's) participation in the activities described herein, **whether caused in whole or in part by the negligence of Step Into Recovery Centers INC or otherwise.**

The undersigned Client, Mike Boorn, (or parent/guardian of the individual named herein), has read the form, fully understands its terms, and understand that he/she (or his/her dependent/ward) has given up substantial rights by signing it and has signed it freely and without any inducement or assurance of any nature and intend it to be a complete and unconditional release of any and all liability to the greatest extent allowed by law and agree that if any portion of this contract is held to be invalid, the balance notwithstanding shall continue in full legal force and effect.

Indemnification of Step Into Recovery Centers INC: The undersigned Client (or his/her parent/guardian) shall at all times hereafter indemnify, hold harmless and, at Step Into Recovery Centers INC's Attorney's option, defend or pay for an attorney selected by the Board to defend Step Into Recovery Centers INC, its officers, agents, servants, and employees against any and all claims, losses, liabilities, and expenditures of any kind, including attorney fees, court costs, and expenses, caused by negligent act or omission of the Client, other clients, Step Into Recovery Centers INC, its employees, agents, servants, or officers, or accruing, resulting from, or related to the undersigned Client in the following situations including, but not limited to, Transportation to the facility from the Client's residence, from the facility to the Client's residence, medication pick-up, medical emergency, and transportation to the nearest mental health Receiving Facility, including, without limitation, any and all claims, demands, or causes of action of any nature whatsoever resulting from injuries or damages sustained by any person or property. The provisions of this section shall survive the expiration or earlier termination of this agreement or the discharge of the client from Step Into Recovery Centers INC.

Venue: This Agreement shall be interpreted and constructed in accordance with and governed by the laws of the State o [ ]. Venue for litigation concerning this agreement shall be in County.

I, Mike Boorn, have read and fully understand the contents herein.

Executed this [ ].

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Universal Precautions for HIV

Universal Precautions refer to the usual and ordinary steps we need to take in order to reduce the risk of infection with HIV, the virus that causes AIDS. These measures are intended to prevent transmission of HIV.

The prevention of the transmission of HIV is based on the avoidance of skin and mucous membrane contact with blood and body fluids.

Protecting yourself from HIV

- Avoid risky behavior
- Protect yourself from sharp injuries
- Wear gloves when in contact with body fluids, if possible
- Wear mask and eye protection when splash injuries are possible
- Call on trained individuals to clean up blood spills

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Universal Precautions for Infection Control

Universal Precautions refer to the usual and ordinary steps you need to take in order to reduce the risk of infectious diseases such as HIV or Hepatitis C.

The prevention of transmission of infectious diseases is based on the avoidance of skin and mucous membrane contact with blood and other body fluids.

AVOID UNNECESSARY RISKS

- If a fellow patient or client needs assistance, please call a staff member immediately.
- When avoidable, don't expose yourself to another person's blood or body fluids.
- Never share needles, razors, or any other*personal* sharp objects.
- Always call on trained individuals to clean up blood or other body fluid spills.

PROTECT YOURSELF

- Use barrier protection to prevent skin and mucous membrane contact with blood and other body fluids.
- Wear face protection if blood or body fluid droplets may be generated during a procedure.
- Wear protective clothing if blood or body fluids may be splashed during a procedure.
- Wash hands and skin immediately and thoroughly if contaminated with blood or body fluids.
- Wash hands immediately after gloves are removed.
- Use care when handling sharp instruments and needles. Place used sharps in labeled, puncture-resistant containers.
- If you have sustained an exposure or puncture wound, immediately flush the exposed area and notify a staff member.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Belongings Placed in the Safe 05/07/2024 12:07 PM

Date: 05/07/2024 12:07 PM

Additional luggage in storage: ☐ Yes ☐ No

Driver's license:

Other IDs:

Insurance Card(s):

Cash:

Checks (blank):

Checks (written):

Wallet:

Credit or debit cards:

Phones and electronic devices

Sharps:

Other items:

Attachments:

Clients are to be encouraged not to keep valuables on the unit and to send them home whenever possible. The facility maintains a safe for safekeeping your money and valuables. The facility shall not be liable for the loss or damage to any pocketbooks, money, jewelry, eyeglass/contact lens, dentures, documents, personal electronic devices or other articles of

value that are personally kept/not deposited in the safe for your security. It is strongly recommended that all items not required and/or needed during your stay in the facility be sent home.

I have reviewed the above statement and am taking responsibility for any items that I keep in my possession and will hold the facility harmless for any loss or damage to such items.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Safe Call 05/07/2024 12:07 PM

Date/Time: 05/07/2024 12:07 PM

Emergency Contact:

Consent Release Signed? ☐ Yes ☐ No

Relationship to Patient:

Phone Number:

Emergency Contact Reached?

When?

What is the follow up plan?

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

HIV/AIDS/TB/STD Informational Fact Sheet (Pre-Test Counseling)

Here are* some *facts about HIV/AIDS/TB/STDs. Please read carefully. Your counselor will review the information with you and answer any questions or clarify any areas that may not be clear. This handout is yours to take with you. You may wish to share this information with your sexual partner or other significant individuals.

WHAT IS IT?

AIDS (Acquired Immune Deficiency Syndrome) is a disease caused by a virus called HIV (HumanImmunodeficiency Virus).

- When a person is infected with HIV, the virus infects and can kill certain cells in the immune system called T- helper cells. This weakens the immune system so that other opportunistic infections can occur. The HIV-infected person is said to have AIDS when they become sick with other specific infections or when the number of T-helper cells has dropped below 200.
- There is no cure for HIV. Although people do not die from HIV, most people who become infected with HIV will eventually develop AIDS. You can have HIV for several years without showing any signs. That means you can have HIV and not even know it. You can also spread HIV during that time to other people. As of 1996, about half of everybody that got HIV would develop AIDS within ten years. Now, with the help of new drug treatments, the time between infection of HIV and the time it takes to develop AIDS can be even longer.

WHO CAN GET HIV/AIDS?

People of any sex, age, and race can get HIV/AIDS. As a matter of fact, it is the ninth leading cause of death among people between the ages of 15-19 and the fifth leading cause of death between the ages of 20-24. HIV/AIDS is the leading cause of death for both black males and females between the age of 25-44. Florida has the third-highest rate of AIDS cases in the country, with estimates as high as 1 in 50 people.

PEOPLE WITH THE HIGHEST RISK OF AIDS AND HIV INFECTIONS ARE:

- People who share needles
- Men who have sex with other men
- Babies born to mothers who have HIV infections
- People who receive blood transfusions or blood products before 1985

- Anyone who has sex with anyone who has or is at risk for AIDS or HIV infection

HOW IS HIV SPREAD?

HIV is spread through bodily fluids like blood, pus, semen, menstrual blood, vaginal secretions, andbreast milk. If your blood comes into contact with any body fluids of an infected person, you may become infected with HIV. You may expose yourself to HIV if you do any of the following with a person who has HIV.

- Have unprotected sex (sex without a condom)

You can get HIV from oral, anal, or vaginal sex, or from sharing sex toys with a person who is infected.

- Share a needle or a syringe with someone who is infected.

This could be sharing a needle to inject drugs, to make tattoos, or to pierce your ear.

- Get infected blood into an open cut or mucous membrane.

This is rare and usually occurs with healthcare workers when it does happen.

- From a mother to a baby.

This can occur before, during birth, or by breast-feeding.

SYMPTOMS

Certain symptoms and conditions may be associated with HIV/AIDS

These symptoms and conditions may include: fever, weight loss, swollen lymph glands in the neck, underarms, or groin, white patches in the mouth (thrush), certain cancers (Kaposi's sarcoma, certain lymphomas, certain invasive cervical cancers), and infections (Pneumocystis pneumonia, certain types of meningitis, toxoplasmosis, certain blood infections, TB, etc...)

TESTING

A blood test may tell if you have HIV infection or AIDS.

You can get an HIV blood test at your doctor's office or at Counseling and Testing Sites throughout Florida. Getting tested is easier than ever and can be done confidentially or anonymously which means no one else will even know your name. They may take a blood sample OR they may simply take a sample of your saliva with a swab. Test results take about 2 weeks to come back and then you can find out the results. Knowing can give you peace of mind and protect other people that are important to you.

Remember, anyone can get HIV/AIDS. Take care of yourself. Protect yourself.

WHAT DOES THE TEST MEAN?

This test detects antibodies to HIV, not the virus itself. Antibodies are the body's reaction to the virus.

A **POSITIVE** test means that a person is infected with HIV and can pass it to others. By itself, a positive test does not mean that a person has AIDS, which is the most advanced stage of HIV infection.

A **NEGATIVE** test means that antibodies to HIV were not detected. This usually means that the person is not infected with HIV. In some cases, however, the infection may have happened too recently for the test to turn positive. The Blood test usually turns positive within 1 month after infection and in almost all cases within 3 months. Therefore, if you were infected very recently, a negative test result could be wrong.

FALSE RESULTS (a negative test in someone who is infected, or a positive test in someone who is not infected) are rare. Indeterminate results (when it is unclear whether the test is positive or negative) also are rare. When a test result does not seem to make sense, a repeat test or special confirmatory tests may help to determine whether a person is or is not infected.

BENEFITS OF BEING TESTED - There are substantial benefits to being tested. Most infected persons may benefit from medications that delay or prevent AIDS and other serious infections. Test results also can help people make choices about contraception or pregnancy. Therefore, all infected persons should have a complete medical checkup, including tests of the immune system; to help their health care providers recommend the best health care. There are other reasons to be tested. Even though everyone should follow safer sex guidelines whether or not they are infected with HIV, many persons find that knowing their test results helps them to protect their partners and themselves. Some persons want to know their test results before beginning a new sexual relationship or becoming pregnant. Others will be reassured by learning that they are not infected.

RISKS AND DISADVANTAGES of BEING TESTED- Many persons with positive or indeterminate test results will experience stress, anxiety, or depression. Some persons with negative tests may continue or increase unsafe behaviors, which would increase the risk of HIV infection. Some persons are afraid that their test results will get into the wrong hands, and that discrimination might result. For these reasons, you should consider your social supports (such as family and friends) and your insurance needs before you are tested.

HOW DO I PROTECT MYSELF?

The best way to protect yourself is to abstain from sex and do not inject drugs.

Here are some ways of limiting your risk of becoming infected with HIV:

- Practice safer sex -(Remember THERE IS NO RISK-FREE SEX!)
    - Have sex with one uninfected partner who only has sex with you.
    - ALWAYS use a barrier for protection.
    - A condom is the most protective prevention strategy. A condom will NOT GUARANTEE that you will not be exposed to HIV but aside from not having sex at all, a condom is your best defense. Be sure to use a condom for oral sex too!

- Use a water-based lubricant such as KY Jelly, Astroglide, or Wet. Don't use an oil-based lubricant (Vaseline, Crisco,

chocolate syrup, etc.). Oil-based lubricants will cause the condom to break down making holes in the condom that HIV can get through.

- Don't use 2 condoms at the same time.
    - Use latex gloves for hand sex and never use these more than once. When you are done with them throw them in the trash.
    - Don't share needles, razors, or toothbrushes. Something to think about:

When you have sex with someone, you could be exposing yourself to everyone that person has had sex with for at least the past 10 years and everyone those people have had sex with as well.

Don't use drugs (especially drugs you have to inject)

- Using drugs weakens your immune system and makes your body less able to protect itself from becoming infected with HIV.
    - Using drugs can affect your ability to make good decisions and you might be more likely to get yourself involved in behavior that will put you at risk.
    - If you decide to still use despite these dangers, do not share needles. If you aren't sure if the needles you are using are safe and you decide to use anyway, washing your paraphernalia (works) in a solution of bleach and then rinse it with water very well 3 times MAY help reduce your chances of contracting HIV. You may want to consider getting treatment for your drug use.

When cleaning up blood or other bodily fluids:

- Practices called Universal Precaution and Standard Precautions, such as the use of:
    - Wearing gowns gloves and goggles and always wash your hands thoroughly after contact.
    - Always disinfect any areas that may have had blood or other bodily fluids on them thoroughly.

WHAT IF I'M PREGNANT? If you are pregnant see a doctor. If you have HIV, you can pass it on to your baby before birth, during birth, or through breastfeeding. But there are medications that can make the chances you will infect your baby much smaller. Talk to a doctor and get tested for HIV as soon as possible if you think you are pregnant or if you want to get pregnant.

WAYS I WON'T GET HIV:

- Shaking hands.
- Eating in a restaurant.
- Using restrooms.
- Donating blood.
- Being bitten by a mosquito or other bug.
- Dry kissing.
- Casual contact like living in the same household, or working with a person who carries HIV. Unless you are exposed to body fluids, you are not at risk for HIV infection.

- In 2003, 6,654 HIV cases were reported in Florida.
- Males account for 64% of the cumulative reported HIV cases, and females account for 36%. The male-to female ratio is 1.8:1.
    - Of the cumulative number of HIV cases, 55% are among blacks, 28% are among whites, and 17% are among Hispanics.
    - In 2003, there were 301,461 HIV tests performed by county public health departments, with 2.2% of the tests being positive.
        - Approximately 100,000 persons, or roughly 11% of the national total, are currently living with infection in Florida.

Tuberculosis

Tuberculosis (TB) is a disease caused by a bacterium called*Mycobacterium Tuberculosis-Tuberculosis (*TB) is a disease that is spread from person to person through the air. TB usually affects the lungs. The bacteria is put into the air when a person with TB of the lung coughs, sneezes, laughs, or sings. TB can also affect other parts of the body, such as the brain, the kidney, or the spine. Tuberculosis is a disease that can be cured if treated properly.

TB can affect anyone of any age-Anyone can get TB, but some people are at higher risk. Those at higher risk include:

- Infants and small children
- People who share the same breathing space (such as family members, friends, coworkers) with someone who has TB disease
- People with low income who live in crowded conditions, have poor nutrition and have poor health care
- Homeless people
    - People born in countries where a lot of people have TB
    - Nursing home residents
        - Prisoners
        - Alcoholics and injection drug users
            - People with medical conditions such as diabetes, kidney failure, and those with weakened immune systems (such as HIV or AIDS)

The symptoms of TB disease may include:

Feeling weak or sick, rapid weight loss (over a few weeks or months), fever, or night sweats. Symptoms of TB of the lungs may include: cough, chest pain, or coughing up blood. Other symptoms depend on the particular part of the body that is affected.

TB infection is different than TB disease:

People with TB disease are sick from bacteria that are active in their body. They usually have one or more of the symptoms of TB. These people are often capable of giving the infection to others. Medications can cure TB disease; usually three or more medications are given to treat TB disease. People with TB infection (without disease) have the bacteria that cause TB in their body. They are not sick because the germ lies inactive in the body. They cannot spread the germ to others. Medications are often prescribed for these people to prevent them from developing TB disease in the future. **A skin test can tell if you have TB infection:**

You can get a TB skin test from a doctor or local health department. A negative test usually means the person is not infected. However, the test may be falsely negative in a person who has been recently infected (it usually takes 2 to 10 weeks after exposure to a person with TB disease for the skin test to be positive). The test may also be falsely negative if the person's immune system is not working properly.

A positive skin test reaction usually means that the person has been infected with TB. It does not necessarily mean that the person has TB disease. Other tests, such as an x-ray or sputum sample, are needed to see if the person has TB disease.

If you have TB infection or disease:

- Do all the required tests that your doctor orders.
- Stay at home until your doctor tells you it is okay to return to work or school. Do not have visitors (especially children) until your doctor says it is okay.
- Keep all your medical appointments.
- Take all your TB medications as prescribed. In Maryland, the local health department works with doctors to treat almost all people with TB disease. The local health department will provide the correct antibiotics and make sure they are taken correctly. Medications must be taken for long periods of time (6 months or more).

STD Frequently Asked Questions

All of these diseases are passed on by having unprotected sex (any kind of sex) with someone who is infected. You cannot tell someone is infected by his or her looks!! Remember, STDs including HIV (the virus which causes AIDS) are passed on by having unprotected sex.

Primary Syphilis

- *Infectious agent is the spirochete Treponema pallidum.*
    - *Symptoms -non-painful sore on the genital area (outside or inside) or on the lip or inside the mouth, caused by sexual contact with someone who has a primary syphilis sore.*

- *Frequently asked questions -*
    - *Do I always know I have it? No, the sore may be where you can't see it (inside the vagina, for example).*
    - *Does the sore last a long time? No, the sore is only present for one or two weeks, then no symptoms until the next stage, secondary syphilis.*
    - *Can a pregnant woman pass syphilis on to her unborn baby? Yes, a pregnant woman with syphilis who is not treated early enough can pass syphilis on to her baby, who can be born critically* ill.

Secondary Syphilis

- Infectious agent is the same as primary syphilis above.
    - Symptoms -non-painful, non-itchy rash typically on palms of hands, soles of feet, may be anywhere on body. Rash is often spots that are darker than the normal skin color.
    - Frequently asked questions -
        - Is the rash contagious? Yes, the rash is very contagious.
        - Is syphilis curable? Yes, it is easily curable with the right type and amount of penicillin.
        - What if I am allergic to penicillin? Another type of antibiotic may be used.

Herpes

- Infectious agent is the herpes simplex virus.
- Symptoms -painful blisters on the genital area can come and go. Some persons have sores that are so mildly painful that they do not know they have them. Others also can have sores in areas that are not seen, again like in the vagina, or mouth.
    - Frequently asked questions -
        - Can I get herpes or pass it on even if there are no sores present? Yes, it may be possible to get it or pass it on even if no sores are present.
            - How long does the infection last? It will remain in your body for the remainder of your life.

You can be infectious to others at periodic times for many years.

Chlamydia

- Infectious agent is Chlamydia trachomatis, bacteria.
    - Symptoms -yellow or mucous-like discharge from the vagina or penis. Usually, the discharge is of a small amount. Most persons do not have any symptoms.
    - Frequently asked questions -
        - Can Chlamydia cause me to become sterile? Yes, untreated Chlamydia can cause infertility or long-term pelvic pain.
        - Can I have it and not know I have it? Yes, you may not have any symptoms but be infected for several years.

Gonorrhea

- Infectious agent is Neisseria gonorrhea, bacteria.
    - Symptoms -yellow or greenish or mucous-like discharge. A female may have burning on urination or pelvic pain. A male often may have burning with urination and may notice a stain in his underwear.
    - Frequently asked questions -
        - Can a male have gonorrhea and not know they have it? Yes, it is possible to not have any symptoms. It is more likely that a female would have milder symptoms, or not have any symptoms than for a male.

Genital warts

- Infectious agent is the human papilloma virus (HPV).
    - Symptoms - cauliflower-like warty growths that may be on the genital area, outside or inside.
    - Frequently asked questions -
        - Why do I have these warts and my partner doesn't? It is possible for one person to have genital warts and their partner to be free of warts.
        - I was told that I have an abnormal Pap smear caused by this virus, why didn't I have warts?

There are several types of HPV, some of which cause genital warts and some cause abnormal Pap smears.

- I have heard warts cause cancer, is this true? Yes, some types of HPV do cause cervical

cancers in women and penile cancer in men.

Remember: If you know you have an STD like Herpes or HPV (genital warts) or HIV, you must protect your future partners from infection. You must tell them before having sex and use condoms if you do have sex.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Specific Authorization for Psychotropic Medications

Name: Mike Boorn MR#: SIR2024-43 DOB: 12/02/1993

Discussion of psychotropic medication should occur within the context of the patient(s) medical history and current overall medication regimen.

I , **Mike Boorn**, hereby authorize the professional staff to administer treatment, limited to the mental health medications indicated below. Other medications may be suggested and discussed:

Antipsychotics:

☐	Abilify 7.5mg-30mg	☐	Clozaril 12.5mg-900mg
☐	Geodon 20mg-160mg	☐	Haldol 0.5mg-80mg PO/IM
☐	Haldol Dec. 25-300mg IM	☐	Loxitane 5mg-250mgPO/IM
☐	Mellaril 10mg-1000mg	☐	Moban 10mg-225mg
☐	Navane 1mg-60mg	☐	Prolixin 0.5mg-75mg IM
☐	Prolixin Dec. 12.5mg-75mg IM	☐	Risperdal 0.25mg-6mg
☐	Serentil 10mg-400mg	☐	Seroquel 12.5mg-900mg
☐	Stelazine 1mg-40mg PO/IM	☐	Thorazine 10mg-2000mgPO/IM
☐	Trilafon 2mg-24mg PO/IM	☐	Zyprexa 2.5mg-40mg

Anxiolytics:

☐	Ativan 0.5mg-12mg PO/IM	☐	Buspar 5mg-60mg
☐	Klonopin 0.5mg-20mg	☐	Librium 5mg-300mg PO/IM
☐	Serax 10mg-120mg	☐	Tranxene 3.75mg-90mg
☐	Valium 2mg-40mg PO/IM	☐	Xanax 0.125mg-10mg

Anti-Depressants:

- ☐ Anafranil 25mg-250mg
- ☐ Asendin 25mg-600mg
- ☐ Celexa 10mg-80mg
- ☐ Cymbalta 40mg-60mg
- ☐ Effexor 25mg-600mg
- ☐ Lexapro 5mg-30mg
- ☐ Luvox 25mg-300mg
- ☐ Nardil 15mg-90mg
- ☐ Pamelor 10mg-200mg
- ☐ Parnate 10mg-50mg
- ☐ Paxil 10mg-50mg
- ☐ Paxil CR 12.5mg-62.5mg
- ☐ Prozac 10mg-80mg
- ☐ Norpramin 10mg-300mg
- ☐ Remeron 7.5mg-60mg
- ☐ Serzone 25mg-600mg
- ☐ Sinequan 10mg-300mg
- ☐ Tofranil 10mg-300mg
- ☐ Trazadone 25mg-600mg
- ☐ Zoloft 25mg-200mg
- ☐ Wellbutrin SR 75mg-450mg

CNS Stimulants/ADHD Meds:

- ☐ Adderal/XR 5mg-30mg
- ☐ Provigil 100mg-400mg
- ☐ Ritalin/SR 5mg-60mg
- ☐ Strattera 18mg-100mg

Hypnotics:

- ☐ Chloral hydrate 250mg-2000mg
- ☐ Restoril 7.5mg-60mg

Mood Stabilizers:

- ☐ Depakene 125mg-3000mg
- ☐ Depakote 125mg-3000mg
- ☐ Gabitril 2mg-56mg
- ☐ Lamictal 25mg-500mg
- ☐ Lithium 150mg-2400mg
- ☐ Tegretol 100mg-1200mg
- ☐ Topamax 25mg-400mg
- ☐ Trileptal 300mg-2400mg
- ☐ Neurontin 100mg-3600mg

Anti-histamines:

- ☐ Benadryl 25mg-200mg PO/IM
- ☐ Periactin 2mg-20mg
- ☐ Vistaril 25mg-300mg PO/IM

Anti-cholinergic:

- ☐ Artane 1mg-15mg
- ☐ Cogentin 0.5mg-8mg PO/IM
- ☐ Symmetrel 100mg-300mg

Antidotes:

- ☐ Antabuse 125-500mg
- ☐ Revia 25mg-150mg
- ☐ Campral 333mg-1998mg

Each subject below has been explained to me in detail, and I have had the opportunity to ask questions and receive answers about treatment:

- The nature of my mental health condition, the purpose of the treatment, and the approximate length of care.
- The reasons for prescribing the medication(s), including the likelihood of my condition improving or not improving with the medication.
- The proposed medications, dosages, and frequency.
- Common short and long-term side effects (including awareness of risks of Tardive Dyskinesia) of the proposed medication, including contraindications and clinically significant interactions with other medications.
- Alternative medications.
- The off-label use of medication.
- I was also given specific written information about the recommended medication(s). I understand that this is only a partial listing of information, and I should discuss all medical problems and medication(s) that I take with my physician.

I can refuse to take the medication(s) at any time if I tell any member of the medical staff.

☐ **I DO** consent to the use of the above medication(s). I give consent voluntarily and understand that this may be revoked orally or in writing at any time.

☐ **I DO NOT** consent to the use of any of the above medication(s).

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Follow-Up Exam 05/07/2024 12:07 PM

Date: 05/07/2024 12:07 PM

Type of Visit: ☐ Weekly ☐ Bi-Monthly ☐ Monthly ☐ Restart ☐ Phone Consult ☐ Other

---

Results of Urine Drug Screen:

Injections

B-12:

B-CPX:

FOLIC:

ATIVAN:

DIAZPM:

Medications:

Medications below include all current active orders logged via Doctor's Orders. These may include medications self-reported by the patient that were logged, medication orders entered at the facility, and medications brought to the facility by the patient ordered to be continued upon admission. If the patient is not being treated in a residential/inpatient setting, this list may not be inclusive of all medications taken by the patient outside of the facility.

Current as of 05/07/2024 12:07 PM:

Notes:

Physical/Clinical Findings/ Supportive Counseling:

Follow-Up Appt: Clinician: Date:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Health History Form 05/07/2024 12:07 PM

Today's Date: 05/07/2024

Date of Last Physical Exam:

Physician's Name:

Age:

Sex:

Height:

Weight:

Check if you are experiencing any of the following:

Headaches:

Shakes/Tremors:

Diarrhea:

Fatigue:

Diabetes:

STD's:

Eye Problems:

Allergies:

Liver Problems:

High Blood Pressure:

Constipation:

Epilepsy:

Loss of Appetite:

Blood Disorders:

Skin Problems:

Breathing Problems:

Tuberculosis:

Nausea/Vomiting:

Frequent Colds:

Insomnia:

Heart Problems:

Weight Problems:

Dental Problems:

Walking Problems:

Menstrual Problems:

Other:

Explain any checked answers:

List all prior hospitalizations:

	Date	Hospital	Condition	Outcome

List ALL medications you are currently taking:

Associated diagnosis for medications listed:

Have you ever been treated for psychiatric/mental health issues/substance abuse (including eating disorder):

If yes, please explain:

Do you have any health problems that may interfere with any recommended treatment?

If yes, please explain:

Physical Exam is required?

Capable of self-preservation?

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

History and Physical Exam 05/07/2024 12:07 PM

	Start time	End time
Date of Exam:	05/07/2024 12:07 PM	

Chief Complaint(s):

Previous Treatment: ***include Mental Health, Substance Abuse, Outpatient Psychiatry, Therapy or Detox.***

	Date	Provider	Treatment	Duration/Frequency	Outcome

***Outcome Codes: 1=Successful Completion 2= AMA/APA 3=Discharged / Non-Compliant 4=Other

Past Medical History:

Surgical History:

Family History:

Social History:

Marital Status:

Children:

Work:

Cigarettes/Vape:

Medications:

Medications below include all current active orders logged via Doctor's Orders. These may include medications self-reported by the patient that were logged, medication orders entered at the facility, and medications brought to the facility by the patient ordered to be continued upon admission. If the patient is not being treated in a residential/inpatient setting, this list may not be inclusive of all medications taken by the patient outside of the facility.

Current as of 05/07/2024 12:07 PM:

Allergies:

No Known Allergies/NKA

Review of Systems

Physical Exam Vitals:	Blood Pressure (systolic/diastolic)	Temperature	Pulse	Respirations	O2 Saturation
	- / -	-	-	-	-

Comments

-

Height/Weight: Height: (n/a) Weight: n/a BMI: n/a

Skin:

HEENT:

Neck:

Respiratory:

Cardiovascular:

Abdominal:

Extremities:

GU/Rectal:

Neurological:

Musculoskeletal:

Mental Status:

Assessment/Plan:

I hereby certify that the services are medically necessary and appropriate to the patient's diagnosis and treatment needs.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Initial Psychiatric Evaluation 05/07/2024 12:07 PM

	Start time	End time
Start and End Time:	05/07/2024 12:07 PM	

I. Identifying Information:

Admit Date/Time: 05/03/2024 03:00 PM

Admission Type: Voluntary ☐ Involuntary ☐

Marital Status:

Allergies/Drug Reactions:

No Known Allergies/NKA

Current Medications:

Medications below include all current active orders logged via Doctor's Orders. These may include medications self-reported by the patient that were logged, medication orders entered at the facility, and medications brought to the facility by the patient ordered to be continued upon admission. If the patient is not being treated in a residential/inpatient setting, this list may not be inclusive of all medications taken by the patient outside of the facility.

Current as of 05/07/2024 12:07 PM:

II. Chief Complaint:

III. History of Present Illness:
(Include a history of present illness, including onset, precipitating factors and reason for the current admission, signs and symptoms, course, and the results of any treatment received.)

IV. Past Psychiatric & Substance Treatment History:

V. Pertinent Past Psychiatric History: ***(check all that apply)***

VI. Background & Social History:
(Include family, educational, vocational,occupational and social history)

VII. Medical/Surgical History:

VIII. Seizure History:

IX. Head/Trauma History:

X. Trauma/Abuse History:

XI. Psychosocial/Development/Family History Overview:

XII. Previous History Suicidal/Homicidal Ideation/Plan:

XIII. Current Suicidal/Homicidal Ideation/Plan:

XIV. Mental Status Exam:

(Check All Symptoms Present)

A. Appearance:

B. Speech:

C. Behavior:

D. Attitude:

E. Mood:

F. Affect:

G. Self and/or Others Aggressive/Destructive Thoughts and Behaviors:

Suicidal Ideation:

Homicidal Ideation:

Self Destructive Behaviors:

H. Thought Process:

I. Thought Content:

J. Vegetative Signs:

XV. Cognitive Assessment:

A. Orientation:

B. Last Five Presidents.
Able to Recall:

C. Learn Three Objects
***(e.g. 3 feathers, 11 envelopes, 29th Avenue)*:**

D. Digit Span *(e.g. 9 6 4 6 1 7)* Number forward Correctly Number backward Correctly

:

E. Repeat Three Objects (See “C”):

F. Intelligence Estimate:

G. Memory:

1. Immediate Recall:

2. Short Term:

3. Long Term:

4. Concentration:

5. Attention:

H. Impulse Control:

I. Introspection:

J. Judgement:

XVI. Strengths & Assets: ***(check all that apply)***

XVII. Liabilities/Barriers to Recovery:

XVIII. Diagnostic Impressions/Diagnosis:

DSM 5 Diagnosis:

Diagnoses

Medical Conditions:

Psychosocial Stressors:

Need for Suicide Precautions:

XIX. The patient has been fully informed by the psychiatrist about the possible risks and probable benefits of their treatment. The patient has expressed to the psychiatrist an understanding of the explanations that were provided by the psychiatrist.

XX. Justification for Detox, Intensive Inpatient, Residential Treatment or PHP Treatment:

XXI. Treatment Recommendations:

XXII. Psychopharmacologic Interventions:

Risks, benefits, side effects, and dosage schedule explained to patient:

Client verbalized understanding of teaching:

Follow-up:

On this examination, the patient demonstrated signs suggestive of Tardive Dyskinesia. The potential risks and long term consequences of this disorder, and treatment alternatives, were discussed and understood by the patient/guardian.

XXIII. Physician Certification of Need for Admission:

As a physician duly licensed to practice medicine, I hereby certify that treatment is medically necessary. I certify that treatment could not be effectively provided at a lesser intensive level of care and that the patient is able to participate in all aspects of the treatment program. All treatment services will be provided to the patient under my direction and under a written plan of care. Having completed this Physician Initial Certification of Need for Admission, I do authorize and order the patient's admission.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Manage Diagnosis Codes 05/07/2024 12:08 PM

Date/Time: 05/07/2024 12:08 PM

Diagnosis:

Diagnoses

Note:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Medical Progress Note 05/07/2024 12:08 PM

	Start time	End time
Date/Time:	05/07/2024 12:08 PM	

Type of Note:

Note:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Medications Informed Consent 05/07/2024 12:08 PM

Date/Time: 05/07/2024 12:08 PM

Medications Informed Consent:

- **The risks and benefits of this medication have been explained to me.**
- **The most common side-effects and adverse reactions have been explained to me.**
- **I understand that I have the right to accept or refuse the medication.**

Current Medications:

Medications below include all current active orders logged via Doctor's Orders. These may include medications self-reported by the patient that were logged, medication orders entered at the facility, and medications brought to the facility by the patient ordered to be continued upon admission. If the patient is not being treated in a residential/inpatient setting, this list may not be inclusive of all medications taken by the patient outside of the facility.

Current as of 05/07/2024 12:08 PM:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Screen - Nutritional 05/07/2024 12:08 PM

Evaluation Date: 05/07/2024

What have you had to eat in the past 24 hours?

Weight (of ≥5% over past 30 days): ☐ Stable ☐ Loss ☐ Gain

Is there any history of an eating disorder?

Allergies:

No Known Allergies/NKA

Please select the appropriate response to each item:

Eats fewer than 2 meals per day: ()

Eats few fruits, vegetables, or milk products: ()

Has tooth or mouth problems that make it hard to eat: ()

Eats alone most of the time: ()

Complains of being thirsty all the time: ()

Gastrointestinal Problems:

Chronic Diarrhea: ()

Constipation: ()

Nausea/Vomiting: ()

Frequent Reflux/Indigestion: ()

Hx. Non-Compliance with Therapeutic Diet: ()

Current Eating Disorder: ()

Knowledge Deficit of Therapeutic Diet and/or Needs, or Patient requires further nutritional education: ()

Appetite: ()

TOTAL SCORE: ()

Score:

- **0's & 1's only** = No further action.
- **Any 2's** = Refer to nutritionist or to physician for further evaluation.

Document referral in Progress Notes.

Referral to Nutritionist or Physician:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Screen - Pain 05/07/2024 12:08 PM

Evaluation Date: 05/07/2024 12:08 PM

PAIN SCREEN

1. Do you currently have any physical pain?

2. Within the past two weeks, have you taken any medications or treatments to control pain?

3. Have you had any significant, reoccurring, or chronic physical pain in the last six months that has not been resolved?

If client responds to "Yes" to any of the three questions, continue with Pain Assessment form.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Self Preservation Statement 05/07/2024 12:08 PM

Evaluation Date: 05/07/2024 12:08 PM

Note: Each criterion must be met for a Patient to be eligible for services

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Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Step Into Recovery Centers INC

Self Harm-Agreement

Client Name: Mike Boorn **MR #: SIR2024-43** **DOB: 12/02/1993**

I agree to refrain from harming, injuring, and/or endangering myself in any way including attempting suicide while I remain in treatment at Step Into Recovery Centers INC.

I agree to seek the assistance of a staff member immediately if and when I have any thoughts of self-harm and/or harm to others, regardless of the time of day or night.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Assignment of Care Team - CUSTOMIZE 05/07/2024 12:10 PM

Date/Time of Assignment: 05/07/2024 12:10 PM

Primary Therapist:

Primary Therapist	Assigned on
None	

Case Manager:

Case Manager	Assigned on
None	

Primary Nurse:

Primary Nurse	Assigned on
None	

Primary Physician:

Primary Physician	Assigned on
None	

Tester:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Bio-psychosocial Assessment 05/07/2024 12:10 PM

Date/Time: 05/07/2024 12:10 PM

I. SOCIAL AREA

A. Family of Origin

1. Where were you raised and by whom?

2. Do you have any siblings?

	Name	Age	Grew Up Together?

3. How were the relationships between family members in the immediate family/in the household?

4. Who do you feel closest to in the family and why?

5. Is there any history of the following:

Mother:

Father:

Step-Parent:

Siblings:

Other:

If YES to any of the above, elaborate:

B. Family of Choice

1. Are you involved in a significant relationship?

If YES, are you satisfied with relationship with partner?

2. Marriage

History:

	Name of Spouse (Ex-Spouse)	Date of Marriage	Date of Divorce	Reason(s) for Divorce

3. Do you have any children?

	Name	Age	Participatory Parent

4. Are you satisfied with your relationship with your children? ☐ Yes ☐ No ☐ N/A

5. Is there any history of the following:

Partner:

Past Partner:

Children:

If YES to any of the above, elaborate:

C. Cultural Influences

1. Were you raised in any specific culture?

2. Do you identify with any specific cultural group?

3. Do you currently practice any specific cultural rituals?

D. Spirituality/Religious Assessment

1. Is religion or spirituality important in your life?

2. Do you use prayer/meditation?

3. How does your faith help you cope with problems in your life?

II. LEGAL HISTORY

1. Is Client currently involved in the Criminal Justice System?

2. Have you ever been incarcerated? ☐ Yes ☐ No

If YES, list incarceration history, most recent first:

	Date	Charges	Duration/Location	Disposition

3. Do you currently owe any restitution?

4. How much will your legal situation influence your progress in treatment:

5. What is the urgency of your legal situation?

6. Is the legal situation related to your current issues with substance use or mental illness?

III. EDUCATIONAL / VOCATIONAL / MILITARY ISSUES

A. Educational History

1. What is the highest grade completed / degree or certificate obtained?

2. Are you currently enrolled and attending school?

3. Do you have any future educational goals?

B. Employment History

1. Has Client ever been employed? ☐ Yes ☐ No

If YES, list employment history (most recent first):

	Job/Position	Employment Dates	Reason for Leaving	Salary

2. Do you need/want any specific vocational training?

3. Have you ever received any vocational training?

C. Military Service

1. Have you ever served in the Military? ☐ Yes ☐ No

If

YES:

	Branch	Length of Service	Type of Discharge	Benefits Received

Additional information / comments concerning Educational / Vocational Issues:

IV. SEXUAL / ABUSE / TRAUMA HISTORY

Describe your present sexual orientation:

Check all that apply:

For all checked, describe below.

If YES, was it alcohol/drug related? ☐ Yes ☐ No ☐ N/A

Explain any checked items above:

Are you currently in or have you ever been involved in an abusive relationship?

TRAUMA ASSESSMENT:

Have you ever experienced any of the following types of trauma?

Significant death of a family member or friend: ☐ Yes ☐ No

Witnessing an Accident: ☐ Yes ☐ No

Community Violence: ☐ Yes ☐ No

Domestic Violence: ☐ Yes ☐ No

Childhood Trauma: ☐ Yes ☐ No

Natural Disaster: ☐ Yes ☐ No

Family Violence: ☐ Yes ☐ No

Neglect: ☐ Yes ☐ No

Any type of physical, sexual or emotional abuse: ☐ Yes ☐ No

School Violence: ☐ Yes ☐ No

Do you have a history of past or current types of trauma listed above, or sexual, psychological or physical abuse or any other type of abuse, and/or neglect, trauma or exploitation explain below:

Do you feel that this trauma may interfere with treatment and/or has led to past relapses?

Do you have a history of sexual, psychological or physical abuse or any other type of abuse, neglect, trauma or exploitation – Is the facility going to provide Trauma Therapy:

V. LEISURE/RECREATIONAL ACTIVITIES

List any hobbies, recreational interests, sports, games or other leisure activities you enjoy:

What effect has your substance use had on your leisure time?

VI. CURRENT SOCIAL ENVIRONMENT

Current Social Situation/Environment (present living arrangement & environment, identify significant relationships with family members, support systems, current social / peer groups and community resources):

VII. CURRENT FINANCIAL STATUS

Current Financial Status & How did you pay for Drug/Alcohol Addiction?

VIII. CONSEQUENCES OF ADDICTION

1. Describe client's consequences of addiction:

Physical
Emotional
Spiritual
Value System
Legal
Financial
Social
Mental
Behavioral

IV. SUBSTANCE USE HISTORY & ASSESSMENT

Substance History:

	First Used	Last Used	Frequency/Duration	Amount	Method	Pattern of Use (Episodic, Experimental, Binge, Continued, Mental/Behavioral)
Alcohol						
Marijuana						
Cocaine (Powder)						
Crack Cocaine						
Crystal Meth						
Heroin						
Suboxone/Zubsolv						
Oxycontin						

Methadone						
Other Opiates						
Benzodiazepines						
Hallucinogens						
Amphetamines						
Inhalants						
Ketamine (Special K)						
Triple C's						
Codeine						
Ecstasy						
Bath Salts						
Flakka						
MDMA/Molly						
Steroids						
K2/Spice						
Kratom						
Kava						
Other OTC Drugs						

Other Drugs Used:

	First Used	Last Used	Frequency/Duration	Amount	Method	Pattern of Use (Episodic, Experimental, Binge, Continued, Mental/Behavioral)

Assessment for Other Addictive Disorders

History of Other Addictive Behaviors:

Eating Disorders?

Have you ever received treatment for an Eating Disorder? ☐ Yes ☐ No

Is Eating Disorder still an issue for you? ☐ Yes ☐ No ☐ N/A

Do you have a history of Gambling?

Do you feel that gambling is an issue for ☐ Yes ☐ No ☐ N/A

you?

Are there other addictive behaviors (work, nicotine, sex, caffeine, shopping, and/or exercising) that the you have a problem with?

Are there any other addictive disorders that will need to be addressed in treatment?

List Drugs of Choice:

Preference	Class	Substance(s)
Primary		
Secondary		
Tertiary		

Drug Craving: (Range 0-10, 10 being highest)

Treatment History

Number of Times:

Previous Treatment:

	Facility (include location)	Treatment Dates	Level(s) of Care	Length of Treatment	Outcome	How long did they stay abstinent?

Describe your treatment and relapse history, including AA experiences and attempts at abstinence/recovery:

What precipitating events lead to relapse (i.e. triggers)?

X. TREATMENT ACCEPTANCE / RESISTANCE DIMENSION

1. Describe your external motivation for Treatment?

2. Describe your internal motivation for Treatment?

3. Relapse/Continued Use Potential

Client's Strengths:

Client's Weaknesses:

Barriers to Treatment:

XI. RECOVERY ENVIRONMENT

1. Do you have an existing positive support system?

2. Is your current living environment conducive to progress in therapy?

3. Are you currently engaged in any substance-free leisure activities or hobbies?

4. What strengths do you have that will assist you in regards to recovery?

5. Additional information / comments concerning recovery environment issues:

XV. INTERVIEW WITH SIGNIFICANT FAMILY MEMBER

(When available in person or by phone)

1. Does family member / significant other view Client's behavior and/or usage as a problem?

2. Has any family member / significant other attempted to address/intervene in Client's behavior and/or usage? ☐ Yes ☐ No

Why or Why Not?

3. Has family member / significant other noticed any changes in Client's behavior?

4. Have there been any traumatic events in the family or specific to the Client?

5. Is family member / significant other willing to participate in Client's treatment?

CLINICAL IMPRESSIONS:

Include the impact of spirituality on the ability of the individual to receive care/services/determination of any barriers to treatment and/or affiliation with certain types of self-help groups, and if any further assessments are needed.

XII. ASSESSMENT OF MENTAL STATUS DURING INTERVIEW

APPEARANCE:

AFFECT:

MOOD:

BEHAVIOR:

ORIENTATION:

INSIGHT:

JUDGMENT:

LEVELS OF IMPAIRMENT / SEVERITY RATINGS

RATE CLIENT'S LEVEL OF IMPAIRMENT & SEVERITY:

RATING/SEVERITY SCALE:

0 – Not at all
1 – Slightly
2 – Moderately
3 – Considerably
4 – Extremely

PROBLEMS: ()

MEDICAL: ()

EMPLOYMENT: ()

PEER SUPPORT: ()

DRUG/ALCOHOL USAGE: ()

LEGAL: ()

FAMILY/SOCIAL: ()

PSYCHIATRIC - MENTAL HEALTH: ()

TOTAL SCORE: ()

OVERALL LEVEL OF IMPAIRMENT & SEVERITY

0	Not at all impaired
1-7	Slightly impaired
8-15	Moderately impaired
16-23	Considerably impaired
24 & OVER	Extremely impaired

RATIONALE FOR TREATMENT AT THIS LEVEL OF CARE:

REASON FOR TREATMENT AT THIS TIME / GOAL FOR TREATMENT:

INTEGRATED DIAGNOSTIC SUMMARY/CLINICAL IMPRESSION:

Diagnosis:

Diagnoses

List Problems Identified in Bio-Psychosocial:

Problem List Empty

If a problem is identified, but not to be treated in treatment, add to Problem List and check to either Defer or Refer.

---

4. Have there been any traumatic events in the family or specific to the Client?

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Consultation Report 05/07/2024 12:10 PM

☐ DETOX ☐ INTENSIVE INPATIENT ☐ RESIDENTIAL ☐ PHP ☐ IOP ☐ OP

Date: 05/07/2024 12:10 PM

Date & Time Called:

To:

From:

Reason for Consultation:

Findings & Recommendations

Consultation Date/Time:

Orders Written? ☐ Yes ☐ No

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Educational Learning Assessment 05/07/2024 12:10 PM

Evaluation Date: 05/07/2024

SECTION A: Educational Learning Assessment

Pre-Treatment Teaching

Did you participate in any pre-treatment education?

Knowledge of Disease:

Knowledge:

Barriers To Learning:

Religious/Cultural Practices

Do you have any religious or cultural practices that may alter your care?

Language/Cognition

Communicate in:

Reading Ability:

Reading Preference:

Readiness for Learning.
Check all that apply:

Individual Educational Needs / Patient & Family.
Check all identified needs that apply:

Preferred Learning Style:

SECTION B: Teaching Needs

Includes but not limited to the following:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Fagerstrom Test for Nicotine Dependence 05/07/2024 12:10 PM

Is smoking "just a habit" or are you addicted? Take this test and find your level of dependence on nicotine.

Date/Time: 05/07/2024 12:10 PM

1. How soon after you wake up do you smoke your first cigarette? ()

(After 60 minutes = 0; 31-60 minutes = 1; 6-30 minutes = 2; Within 5 minutes = 3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden? ()

(No = 0; Yes = 1)

3. Which cigarette would you hate most to give up? ()

(The first one in the morning = 1; Any other than the first one in the morning = 0)

4. How many cigarettes per day do you smoke? ()

(10 or less = 0; 11 to 20 = 1; 21 to 30 = 2; 31 or more = 4)

5. Do you smoke more frequently during the first hours after awakening then during the rest of the day? ()

(No = 0; Yes = 1)

6. Do you smoke even if you are so ill that you are in bed most of the day? ()

(No = 0; Yes = 1)

Total Score: ()

Your level of dependency on nicotine is:

☐ Score 1-2: Low dependence ☐ Score 3-4: Low to moderate dependence ☐ Score 5-7: Moderate dependence

☐ Score 8+: High dependence

Heatherton, TF, Kozlowski LT, Frecker RC, Fagerstrom K.O. The Fagerstrom test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire, British Journal of Addictions 1991; 86:1119-27

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Family Session Note 05/07/2024 12:11 PM

	Start time	End time
Date/Time of Session:	05/07/2024 12:11 PM	

Participant of Family Session:

Type of Contact:

Summary of Family Session:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Initial Aftercare Plan 05/07/2024 12:11 PM

Date: 05/07/2024

---

1) After treatment I will

2) After treatment I will

3) I want to develop _____ in treatment

4) I need help with

5) Therapeutic Resources

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Legal Assessment 05/07/2024 12:11 PM

Date/Time: 05/07/2024 12:11 PM

---

1. Have you ever committed a crime?

---

2. What was the first crime you ever committed?

---

3. How old were you the first time you committed?

Sell to Dealers:

Manufactured Drugs:

Shoplifting:

Robbery (including drugs):

Motor Vehicle/Grand Theft Auto:

Con Game:

Petty Theft:

Stolen Goods (sell, trade, own):

Weapon:

Other Crime:

Other Theft (including drugs):

Smuggle Drugs:

Sell to Users:

Burglary:

Prostitution (for drugs or money):

Pickpocket:

Bad Paper (Rx, check, credit card):

Unarmed Assault:

Other Assault:

---

4. Have often did you commit the following crimes?

Sell to Dealers:

Manufactured Drugs:

Shoplifting:

Robbery (including drugs):

Motor Vehicle/Grand Theft Auto:

Con Game:

Stolen Goods (sell, trade, own):

Weapon:

Other Crime:

Other Theft (including drugs):

Smuggle Drugs:

Sell to Users:

Burglary:

Prostitution (for drugs or money):

Pickpocket:

Bad Paper (Rx, check, credit card):

Unarmed Assault:

Other Assault:

---

5. Describe the first time you were arrested:
Specify age, offense, impaired, co-defendant, outcome/disposition: never prosecuted, found not guilty, suspended sentence, probation, incarceration, probation/parole, community control, community service, conditions of probation

6. How many times have you been arrested in your lifetime?

7. How old were you when you were first incarcerated? ***Specify age and timeframe***

8. Describe current legal situation (*probation/parole; child welfare involvement; DUI; restraining order, community control; conditions of probation*). If currently involved, give name of probation/parole officer/community control officer; length of probation/parole; conditions of probation/parole:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Intervention Note 05/07/2024 12:11 PM

	Start time	End time
Date/Time of Intervention:	05/07/2024 12:11 PM	

Summary of Intervention:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Progress Note 05/07/2024 12:11 PM

	Start time	End time
Date of Service:	05/07/2024 12:11 PM	

☐ DETOX ☐ INTENSIVE INPATIENT ☐ RESIDENTIAL ☐ PHP ☐ IOP ☐ OP

Progress Note:

Note:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Social Risk Assessment 05/07/2024 12:11 PM

Evaluation Date: 05/07/2024 12:11 PM

Instructions: Ask the Client the following questions and indicate below with a check on the Yes or No box.

1. Have you ever taken drugs using a needle?	☐ Yes ☐ No
2. Are you the sex partner of a person diagnosed with HIV/AIDS?	☐ Yes ☐ No
3. Have you ever had sex while using non-injecting drugs?	☐ Yes ☐ No
4. Have you ever had sex in exchange for money, drugs, etc?	☐ Yes ☐ No
5. Do you currently have a sexually transmitted disease (STD)?	☐ Yes ☐ No
6. Have you ever been diagnosed with an STD?	☐ Yes ☐ No
7. Are you the child of a woman who has HIV/AIDS?	☐ Yes ☐ No
8. Did you receive any blood or blood products between 1977 and 1985?	☐ Yes ☐ No
9. Have you been exposed to HIV/AIDS through the Health Care Industry?	☐ Yes ☐ No
10. Have you had sex with more than one person in the past year?	☐ Yes ☐ No
11. Are you a survivor of a sexual assault?	☐ Yes ☐ No
12. Have you ever had sexual relations with an injection drug user?	☐ Yes ☐ No
13. Have you ever had sex with a man you know had sex with another man in the past?	☐ Yes ☐ No
14. Have you ever had sex with a person who would be considered at risk for HIV/AIDS?	☐ Yes ☐ No
15. Have you ever been tested for HIV/AIDS?	☐ Yes ☐ No
16. Have you tested positive for HIV/AIDS?	☐ Yes ☐ No

If Yes, give date:

17. Have you ever shared needles or "works"? ☐ Yes ☐ No

18. Have you ever experienced blackouts when under the influence of a drug and/or alcohol? ☐ Yes ☐ No

19. Have you ever had Herpes, Hepatitis B, Syphilis, Gonorrhea, Chlamydia or Genital Sores (sores on the sex organs)? ☐ Yes ☐ No

20. Would you like to be referred for HIV testing? ☐ Yes ☐ No

---

If the Client answers Yes to Question #20, the Client must be referred for HIV testing.

If the Client answers Yes to 5 or more questions, they may be at high risk for HIV – Encourage the Client to be referred for testing.

Location of Referral:

Date of Referral:

HIV pre and post counseling will be provided by this facility: ☐ Yes ☐ No

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Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Spiritual Assessment 05/07/2024 12:11 PM

Date: 05/07/2024

Note: The following assessment is to be used for informational purposes only. It is not intended to reflect anything else other than the client's spiritual inclination.

A. SOURCES OF HOPE

1. What are your sources of hope and strength?

2. What do you hold on to during difficult times?

3. What sustains you and keeps you going?

B. RELIGIOUS BACKGROUND AND BELIEFS

1. Did you practice any religion when you were growing up? ☐ Yes ☐ No

2. Do you practice a religion currently?

3. Do you believe in God or a Higher Power? ☐ Yes ☐ No

4. How would you describe God/Higher Power? Personal or impersonal? Loving or stern?

C. SPIRITUAL MEANING AND VALUES

1. Do you follow any spiritual path or practice?

2. What significant spiritual experiences have you had?

D. PRAYER/MEDITATE EXPERIENCES

1. Do you pray or meditate? ☐ Yes ☐ No

2. When do you pray or meditate?

E. FAITH AND BELIEFS

1. Do you consider yourself spiritual or religious? ☐ Yes ☐ No

2. What are your spiritual or religious beliefs?

3. What things do you believe in that give meaning to your life?

F. IMPORTANCE AND INFLUENCE

1. Is religion/spirituality important in your life? ☐ Yes ☐ No

2. How have your religion/spirituality influenced your behavior and mood during your recovery?

G. COMMUNITY

1. Are you part of a spiritual or religious community? ☐ Yes ☐ No

Explain:

Spiritual Assesment Summary

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Trauma Assessment 05/07/2024 12:11 PM

Date/Time: 05/07/2024 12:11 PM

This test is to help determine your symptoms of trauma. ***Please answer True or False for each of the following.***

---

1. Have you experienced or been exposed to a traumatic event? ()

Please list your traumas:

2. During the traumatic event, did you experience or witness serious injury or death, or the threat of injury or death? ()

3. During the traumatic event did you feel intense fear, helplessness, and/or horror? ()

4. Do you regularly experience intrusive thoughts or images about the traumatic event? ()

5. Do you sometimes feel like you are re-living the event or that it is happening all over again? ()

6. Do you have recurrent nightmares or distressing dreams about the traumatic event? ()

7. Do you feel intense distress when something reminds you of the traumatic event, whether it's something you think about or something you see? ()

8. Do you try to avoid thoughts, feelings, or conversations that remind you of the traumatic event? ()

9. Do you try to avoid activities, people, or places that remind you of the traumatic event? ()

10. Are you unable to remember something important about the traumatic event? ()

11. Since the trauma took place, do you feel less interested in activities or hobbies that you once enjoyed? ()

12. Since the trauma took place, do you feel distant from other people or have difficulty trusting them? ()

13. Since the trauma took place, do you have difficulty experiencing or showing emotions?	()
14. Do you feel that your future will not be "normal" -- that you won't have a career, marriage, children, or a normal life span?	()
15. Since the traumatic event, have you had difficulty falling or staying asleep?	()
16. Have you felt irritable or have you had outbursts of anger?	()
17. Have you had difficulty concentrating, since the trauma?	()
18. Do you feel guilty because others died or were hurt during the traumatic event but you survived it?	()
19. Do you often feel jumpy or startle easily?	()
20. Do you often feel hypervigilant, that is, are you constantly feeling and acting ready for any kind of threat?	()
21. Have you been experiencing symptoms for more than one month?	()
22. Do your symptoms interfere with normal routines, work or school, or social activities?	()
23. Do your symptoms interfere with ability to stay sober/clean?	()

Score: ()

1 - 3	Mild Symptoms
4 - 9	Moderate Symptoms
10 - 23	Severe Symptoms

Clinical Assessment

This section to be completed by a Licensed Professional - (Include: Recommendations, Actions, Treatment plan, and/or Referral to be made and/or addressed during treatment & how symptoms may or may not effect treatment, treatment outcome and recovery)

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Tuberculosis Skin Testing Questionnaire 05/07/2024 12:11 PM

Date/Time: 05/07/2024 12:11 PM

Please check YES or NO in response to the following questions:

1. Are you a recent contact to an infectious case of tuberculosis? ☐ No ☐ Yes

2. Have you ever had an organ transplant? ☐ No ☐ Yes

3. Are you a recent (within the last 5 years) immigrant from a country with a high rate of TB?
If yes, what country?

4. Have you ever injected drugs? ☐ No ☐ Yes

5. Have you been in jail, prison, or a nursing home? ☐ No ☐ Yes

6. Have you ever worked in a lab that processed TB specimens? ☐ No ☐ Yes

7. Do you have any of the following medical conditions? ☐ No ☐ Yes
Check all that apply:

8. Have you ever been told you have an abnormal chest x-ray? ☐ No ☐ Yes

9. Have you had any of the following symptoms recently? ☐ No ☐ Yes
Check all that apply:

If you answered NO to all of these questions, you do not fall into one of the groups that should receive a skin test.
If you answered YES to any of these questions, you will be further evaluated by a Nurse, Physician, or the County Health Department Nurse.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Weekly Progress Note 05/07/2024 12:11 PM

	Start time	End time
Date/Time of Service:	05/07/2024 12:11 PM	

Level of Care: DETOX ☐ INTENSIVE INPATIENT ☐ RESIDENTIAL ☐ PHP ☐ IOP ☐ OP ☐

ATTENDANCE:

GENERAL APPEARANCE:

BEHAVIORS:

MOOD/AFFECT:

Evidenced by:

THOUGHT PROCESS/CONTENT:

LEVEL OF PARTICIPATION/MOTIVATION:

Progress Noted:

Staff intervention/Plan:

Therapeutic Value/Benefit for Client/Response/Comments:

Note:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Individualized Treatment Plan 05/07/2024 12:29 PM

Date Established: 05/07/2024 12:29 PM

Problem (in patient's own words):

Modality:

Problem:

Client Statement: I have participated in the development and review of this treatment plan, have received a copy of this treatment plan and I agree to participate in this part of my treatment to the best of my ability.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Problem List 05/07/2024 12:29 PM

Date of Service: 05/07/2024 12:29 PM

Problem List:

Problem List Empty

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Case Management Assessment 05/07/2024 12:30 PM

Evaluation Date: 05/07/2024

Does client have any needs regarding housing?

Does client have any employment needs?

Does client have any employability skills, past educational or vocational training.

Does client have any personal interests, values and vocational preferences?

Does client have any skills and supports to assist client to maintain employment?

Does client have any education needs, preferences or goals?

Does client have any transportation needs?

Does client have crisis support needs?

Does client have any financial needs or goals?

Does client have any housekeeping needs?

Does client have any social supports?

Does client have a preference related to spiritually or religion?

Does client have any leisure or recreational activities they are involved in?

Does client have any personal grooming or hygiene needs?

Is client able to shop for necessities?

Does client budget his finances?

Is client involved in banking?

Does client use public transportation?

Is client accessing any community resources?

Does client need social or communication training?

Is client involved in any volunteer activity?

Is client able to access health care?

Based on the above assessment list most important needs at this time

---

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Case Management Treatment Plan 05/07/2024 12:30 PM

Date Established: 05/07/2024

Problem Statement:

Goal 1: Client will increase knowledge of his current needs (legal, educational, medical and financial and implement a plan to address those needs during and after treatment so that the client can develop self sufficiency.

Measurable Behavioral Objectives	Interventions: Tasks to Achieve Objective	Frequency
Complete a Case Management Assessment within 7 days of Admission.	Client will meet with the case manager for an initial session and complete the Case Management Assessment	Within 7 days of admission

Target date	Status	Date/Comment	By

Measurable Behavioral Objectives	Interventions: Tasks to Achieve Objective	Frequency
Client and case manager will meet once a week to address any ongoing case management concerns and resolve any legal /educational/employment/ financial issues.	Client and case manager will meet weekly to address ongoing case management needs by addressing the clients current needs: **Legal**: Upcoming Court Cases, Open Cases (i.e., child, divorce, criminal, civil, etc), Probation, Etc. **Educational**: Course work, school applications, school deferment, etc. **Employment**: Family Medical Leave, short term disability, Resume Building, job searches, vocational training. **Medical**: Medical, Psychiatric and therapeutic referral post treatment. **Financial**: Bank accounts, financial responsibility (bills), and financial issues, Bankruptcy, transportation, housing, etc. **Other**: To Be determined at assessment.	Once per week

Target date	Status	Date/Comment	By

Client will identify 3 ways to maintain sobriety after treatment.	Client will complete: **Weekly Schedule** **Sober fun plan** **Goal List**	Once

Target date	Status	Date/Comment	By

Client will develop a comprehensive discharge plan.	Client will develop a discharge plan that includes plans for employment, a place to live and sobriety (daily plan, home group meetings, and attendance at (#) of meetings per week.	Once

Target date	Status	Date/Comment	By

Target date	Status	Date/Comment	By

Client Statement: I have participated in the development and review of this treatment plan, have received a copy of this treatment plan and I agree to participate in this part of my treatment to the best of my ability.

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

LOCUS Assessment with Scoring 05/07/2024 12:30 PM

Evaluation Date/Time: 05/07/2024 12:30 PM

I. Risk of Harm ()

Evidence

II. Functional Status ()

Evidence

III. Co-occurring Disorders ()

Evidence

IV. Recovery Environment

A) Level of Stress ()

Evidence

B) Level of Support ()

Evidence

V. Treatment and Recovery History ()

Evidence

VI. Engagement ()

Evidence

Composite Score ()

Level 1 – 10-13

Level 2 – 14-16

Level 3 – 17-19

Level 4 – 20-22

Level 5 – 23+

Placement Grid Level of Care - LOC

Clinician Recommended LOC

Clinical Justification if Placement Grid LOC is different than Clinician Recommended LOC

Preliminary Recommendations Based on Assessment:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Utilization Review

Mental Status Exam

Appearance:

Attitude:

Behavior:

Eye Contact:

Mood:

Affect

Speech:

Thought Process:

Thought Content:

Perception

Orientation:

Memory:

Insight:

Judgment:

Impulse Control:

Hours of sleep:

Sleep details:

Appetite Scale:

Appetite Details:

ADL's Checklist

Bathing

Grooming

Dressing

Oral Care

Toileting

Transferring

Walking

Climbing Stairs

Eating

Shopping

Cooking

Managing Medications

Using the phone

Housework

Doing Laundry

Driving

Managing Finances

Vitals

Blood Pressure (systolic/diastolic)	Temperature	Pulse	Respirations	O2 Saturation	Comments
- / -	-	-	-	-	-

Current Medications

Medications below include all current active orders logged via Doctor's Orders. These may include medications self-reported by the patient that were logged, medication orders entered at the facility, and medications brought to the facility by the

patient ordered to be continued upon admission. If the patient is not being treated in a residential/inpatient setting, this list may not be inclusive of all medications taken by the patient outside of the facility.

Current as of 05/07/2024 12:30 PM:

Current Symptoms

Biomedical condition and how its a barrier in treatment

Progress

Specific Goals

Assignments being worked on

Barriers to step-down/need for 24x7 monitoring

Discharge/Aftercare plan

Family Sessions Update

Participation in Treatment

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Breathalyzer Test Results 05/07/2024 12:35 PM

Date: 05/07/2024

Type of Test:

Breathalyzer:

Attachments/Scans:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Drug Screen 05/07/2024 12:35 PM

Date: 05/07/2024

Requisition #:

Breathalyzer:

Temperature:

Drug Screen Result:

Attachments/Scans:

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Insurance Information

Insurance	Policy No.	Effective Date	Termination Date	Status	Insurance Type/Priority
Anthem Blue Cross	NSA0555668gH			Active	

Internal ID / External ID	Group Plan Name	Group ID	Plan Type	Payor Type	Insurance Phone
126670034 /					

Rx Name	Rx Group	Rx BIN	Rx PCN	Rx Phone	Plan Period

Claims

Street Address 1	Street Address 2	Claims Fax

City	State	ZIP Code	Country

Subscriber	Relationship of Patient to Subscriber	SSN	DOB	Gender
Mike Boorn	Self		12/02/1993	Male

Subscriber Address Street	Subscriber Address Street 2	Subscriber City
6901 Canby Ave		Reseda

Subscriber Address Zip	Subscriber Address State	Subscriber Address Country
91335	CA	

Vital Signs

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Date	Blood Pressure Systolic	Blood Pressure Diastolic	Temperature	Oxygen Saturation	Pulse	Respiration	Comments	Logged By	Logged At

Glucose Logs

No records available.

Weights

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

No height/weight records.

Heights

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Date	Height	Logged By	Logged At

Orthostatic Vital Signs

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

	Lying		Sitting		Standing							
Date	BP	HR	BP	HR	BP	HR	Resp.	Temp.	O2	Comments	Logged At	Logged By

CIWA-Ar

No CIWA-Ar assessment logged

CIWA-B

No CIWA-B assessment logged

COWS

No COWS assessment logged

Medications Brought In

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC (GMT-08:00) Pacific Time (US & Canada)

No Medications Brought In Logged.

Rounds

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

MAT Orders

Mike Boorn ♂ SIR2024-43

Birthdate: 12/02/1993

Allergies: No Known Allergies/NKA

Admission: 05/03/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Current/Active Order ***No Current/Active Order.***

Order History

Start Date	End Date	Phase	Order Type	Medication	Dose	Instructions	Ordered By	Entered By	Discontinued By	Status