# PATIENT INFORMATION

## Demographics

**Full Name:**
Shane James Export

**Date of Birth:**
2000-10-25

**Age:**
24

**Sex:**
male

**Gender Identity:**
Male

**Marital Status:**
Divorced

**Race:**
American Indian/Alaska Native

**Ethnicity:**
Cuban

**Preferred Language:**
English, Old (ca.450-1100)

**Occupation:**
Product Manager

## Contact Information

**Address:**
123 East St

**City, State ZIP:**
Werst, NE 34353

**Country:**
United States

**Phone:**
1-231-231-23123

**Alternate Phone:**
1-231-231-2312

**Email:**
test@test.com

**Employer:**
Kipu Health

**Employer Phone:**
N/A

## Emergency Contacts

**Name:**
Shawnie James

**Relationship:**
Spouse

**Contact Type:**
Emergency

**Phone:**
1-231-231-2312

**Email:**
sawnie@email.com

**Name:**
Albert Hitchcock

**Relationship:**
Probation Officer

**Contact Type:**
Emergency

**Phone:**
1-231-231-2312

**Email:**
N/A

## Identifiers

**Medical Record Number:**
DBH2025-24

**Patient Number:**
N/A

**SSN:**
***-**-****

**CID:**
123123

## Allergies

**Allergen:**
Pollen

**Allergy Type:**
Other

**Reaction:**
Hives

**Severity:**
N/A

**Status:**
Active

# INSURANCE INFORMATION

## Insurance Policy - CareFirst BCBS - DB National Capital Area

**Insurance Company:**
CareFirst BCBS - DB National Capital Area

**Policy Number:**
12312312

**Group ID:**
N/A

**Status:**
Active

**Effective Date:**
2025-10-15

**Termination Date:**
N/A

**Insurance Type:**
Primary

**Payer ID:**
9999991

### Subscriber Information

**Name:**
Shane Export

**Relationship:**
Self

**Date of Birth:**
2000-10-25

**Gender:**
Male

**Address:**
123 East St

**City, State ZIP:**
Werst, NE 34353

**Employer:**
N/A

## Insurance Policy - Test Payor

**Insurance Company:**
Test Payor

**Policy Number:**
123123123

**Group ID:**
N/A

**Status:**
Active

**Effective Date:**
2025-10-16

**Termination Date:**
N/A

**Insurance Type:**
Secondary

**Payer ID:**
12345678

### Subscriber Information

**Name:**
Shane Export

**Relationship:**
Self

**Date of Birth:**
2000-10-25

**Address:**
123 East St

**City, State ZIP:**
Werst, NE 34353

**Employer:**
Kipu Health

**Gender:**
Male

# PATIENT CONTACTS

## Shawnie James

**Relationship:**
Spouse

**Contact Type:**
Emergency

**Phone:**
1-231-231-2312

**Alternative Phone:**
222-555-55555

**Email:**
sawnie@email.com

**Fax:**
222-222-2222

**Address:**
9 Wilburn Rd
Asheville, NC 28806

**Notes:**
This is my wife

## Albert Hitchcock

**Relationship:**
Probation Officer

**Contact Type:**
Emergency

**Phone:**
1-231-231-2312

**Alternative Phone:**
N/A

**Email:**
N/A

**Fax:**
N/A

**Address:**
N/A

**Notes:**
N/A

# MEDICATION ORDERS

| Medication Name | Order Type | Route | PRN | Start Date | End Date | Status | Provider |
|---|---|---|---|---|---|---|---|
| Ativan (lorazepam), 1mg/1 x 2 caps , oral, tablet, every 8 hours, for 3 days, PRN | Consistent Dose | oral | Yes | 10/16/2025 | 10/19/2025 | Pending Order Review | KioskSSO KioskCognito |
| Epipen, .3mg/.3ml x 1 cap , intramuscular, injection, once a day, until further notice, PRN | Open End | intramuscular | Yes | 10/16/2025 | N/A | Pending Order Review | KioskSSO KioskCognito |
| Lorazepam, 1 mg x 1 Tablet(s) , oral, tablet, every 8 hours, for 7 days | Consistent Dose | oral | No | 10/16/2025 | 10/23/2025 | Pending Order Review | KioskSSO KioskCognito |
| Multi-vitamin, custom x 1 cap , oral, tablet, once a day, in the morning, for 7 days | Open End | oral | No | 10/16/2025 | 10/23/2025 | Pending Order Review | KioskSSO KioskCognito |
| Quetiapine Fumarate, 25mg/1 x 1 cap , oral, tablet, every 8 hours, until further notice, PRN | Open End | oral | Yes | 10/16/2025 | N/A | Pending Order Review | KioskSSO KioskCognito |
| Quetiapine Fumarate, 50mg/1 x 1 cap , oral, tablet, once a day, at bedtime, until further notice, PRN | Open End | oral | No | 10/16/2025 | N/A | Pending Order Review | KioskSSO KioskCognito |
| Suboxone, 2mg/1 x 2 caps , sublingual, film, every 8 hours, for 3 days, PRN | Consistent Dose | sublingual | Yes | 10/16/2025 | 10/19/2025 | Pending Order Review | KioskSSO KioskCognito |

Ativan (lorazepam), 1mg/1 x 2 caps , oral, tablet, every 8 hours, for 3 days, PRN: For signs and symptoms of alcohol and/or benzodiazepine withdrawal

 Ativan (lorazepam), 1mg/1 x 2 caps , oral, tablet, every 8 hours, for 3 days, PRN: Hold if BP < 90/60

Epipen, .3mg/.3ml x 1 cap , intramuscular, injection, once a day, until further notice, PRN: For allergic reaction

Lorazepam, 1 mg x 1 Tablet(s) , oral, tablet, every 8 hours, for 7 days: Lorax

Multi-vitamin, custom x 1 cap , oral, tablet, once a day, in the morning, for 7 days: For supplement

Quetiapine Fumarate, 25mg/1 x 1 cap , oral, tablet, every 8 hours, until further notice, PRN: For anxiety and/or agitation

Quetiapine Fumarate, 50mg/1 x 1 cap , oral, tablet, once a day, at bedtime, until further notice, PRN: For restlessness

Suboxone, 2mg/1 x 2 caps , sublingual, film, every 8 hours, for 3 days, PRN: For signs and symptoms of opiate/opioid withdrawal

 Suboxone, 2mg/1 x 2 caps , sublingual, film, every 8 hours, for 3 days, PRN: Do not use if patient tested positive for Methadone. Hold if BP < 90/60

# MEDICATION ADMINISTRATION RECORD (MAR)

| Medication Name | Dose Given | Route | Scheduled Time | Administration Time | Administered By |
|---|---|---|---|---|---|
| Lorazepam | 1 mg | oral | 10/16/2025, 10:15:00 AM | 10/16/2025, 11:45:28 AM | Shane Carroll, Product Manager |
| Multi-vitamin | custom | oral | 10/16/2025, 12:00:00 PM | 10/16/2025, 11:45:34 AM | Shane Carroll, Product Manager |

# INTEGRATED ASSESSMENTS

## Vital Signs

| Timestamp | BP Systolic | BP Diastolic | Temp | Pulse | Resp | O2 Sat | Recorded By |
|---|---|---|---|---|---|---|---|
| 10/16/2025, 11:55:15 AM | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 10/16/2025, 11:54:50 AM | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 10/16/2025, 11:54:00 AM | N/A | N/A | N/A | N/A | N/A | N/A | Shane Carroll, Product Manager |
| 10/16/2025, 11:45:00 AM | 110 | 80 | 94.0 | 188 | 10 | 80 | Shane Carroll, Product Manager |
| 10/16/2025, 10:26:00 AM | 120 | 80 | 98.0 | 100 | 14 | 99 | Shane Carroll, Product Manager |

## Glucose

| Timestamp | Reading | Type of Check | Intervention | Note | Recorded By |
|---|---|---|---|---|---|
| 10/16/2025, 10:27:00 AM | 120 | Before Breakfast | Physician Called | N/A | Shane Carroll, Product Manager |
| 10/16/2025, 11:46:00 AM | 120 | Before Lunch | Physician Called | N/A | Shane Carroll, Product Manager |

## Orthostatic Vitals

| Timestamp | BP Lying | BP Sitting | BP Standing | Pulse Lying | Pulse Sitting | Pulse Standing | Temp | Recorded By |
|---|---|---|---|---|---|---|---|---|
| 10/16/2025, 11:54:50 AM | N/A/N/A | N/A/N/A | N/A/N/A | N/A | N/A | N/A | N/A | N/A |
| 10/16/2025, 11:54:00 AM | N/A/N/A | N/A/N/A | N/A/N/A | N/A | N/A | N/A | N/A | Shane Carroll, Product Manager |
| 10/16/2025, 11:47:00 AM | 120/100 | 110/120 | 100/80 | 98 | 70 | 150 | 100 | Shane Carroll, Product Manager |
| 10/16/2025, 10:27:00 AM | 120/80 | 150/60 | 140/100 | 100 | 100 | 100 | 98 | Shane Carroll, Product Manager |

## CIWA-AR

| Timestamp | Total Score | Nausea | Tremor | Sweats | Anxiety | Agitation | Tactile | Auditory | Visual | Headache | Sensorium |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10/16/2025, 11:45:00 AM | 24 | 3 | 3 | 1 | 5 | 1 | 3 | 3 | 1 | 1 | 3 |
| 10/16/2025, 10:26:00 AM | 10 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

## CIWA-B

| Timestamp | Total Score | Anxiety | Tremors | Sweating | Weakness | Muscle Ache | Head Ache | Visual | Sleep | Appetite | Status | Recor By |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10/16/2025, 11:46:00 AM | 56 | 3 | 4 | 3 | 4 | 4 | 3 | 4 | 3 | 4 | active | Shane Carrol Produ Manag |
| 10/16/2025, 10:27:00 AM | 20 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | active | Shane Carrol Produ Manag |

## COWS

| Timestamp | Total Score | Pulse Rate | Sweating | Restlessness | Pupil Size | Bone/ Joint Ache | Runny Nose | GI Upset | Tremor | Yawning | Anxiety/ Irritability | Goo |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10/16/2025, 11:46:00 AM | 8 | 1 | 2 | 1 | 2 | N/A | N/A | N/A | 1 | N/A | 1 | N/A |
| 10/16/2025, 10:27:00 AM | 13 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 3 |

## Height & Weight

| Timestamp | Height | Weight |
|---|---|---|
| 10/16/2025, 12:24:58 PM | 69.0 in | 110.0 lbs |

## Height & Weight

| Timestamp | Height | Weight |
|---|---|---|
| 10/16/2025, 12:24:58 PM | 69.0 in | 110.0 lbs |

## GROUP SESSIONS

### Men's Process Group B

**Start Time:**
10/16/2025, 3:45:00 PM

**End Time:**
10/16/2025, 5:45:00 PM

**Duration:**
02:00

**Attendance Status:**
Attended

**Personal Notes:**
TestTest

**Session Topic:**
Topic

**Session Notes:**
Group Description

**Present:**
Yes

**Completed:**
Yes

**Date Completed:**
10/16/2025

**Billable:**
No

# portal consentz

**Form Name:**
portal consentz

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

Who will this be: n/a

Relationship to adolescent: n/a

Release of information obtained for this person Clinician Initial: n/a

## consentVeroDropDown

**Form Name:**
consentVeroDropDown

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

Data Fields

East 4-D, Shane James Export, DBH2025-24, , 10/25/2000, male, 24, 123-12-3123, 10/15/2025,123 East St

Werst, NE 34353

United States, test@test.com, 1-231-231-23123, Residential Updated -#10 , Male, F11.40

CareFirst BCBS - DB National Capital Area, Test Payor, CareFirst BCBS - DB National Capital Area Policy 12312312, Test Payor Policy 123123123,

QA Master, 123 Test Street, Miami, FL, 33139, 786-555-9999, , Miami-Dade

Locations fields will default to the corresponding company fields if the patient does not have a location assigned:

Demo Behavioral Health Center TM1, 1 Main Street, Phoenix, AZ, 00000, 210-123-456-7890, 210-098-7654,

Form Fields

n/a spouse n/a

n/a

n/a ☑ ☐ ☐Yes ☐No n/a

# ROI - import

**Form Name:**
ROI - import

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

Crossroads

Authorization to Release Confidential Information

Name of Contact: test

Relationship to Client: etsste

Crossroads may:

☐ Obtain records from

☐ Disclose records to

☐ Verbally discuss my PHI with

Forward Records to:

☐ Admissions ( Phone: 207-773-9931, Fax: 207-289-1262)

☐ Back Cove Women’s Residential ( Phone:207-772-1187, Fax:207-772-0974)

☐ CAMP (Phone:207-892-2192, Fax: 207-892-2146)

☐ Outpatient Services ( Phone:207-773-9931, Fax:207-879-5576)

Specific information to be disclosed:

Note: Only records generated by Crossroads will be disclosed unless non-SUD third party documentation is specifically identified.

☐ Presence in treatment

☐ Progress notes

☐ Comprehensive/other assessments

☐ Treatment plans

☐ Progress in treatment

☐ Diagnoses

☐ Billing / authorization info

☐ Medication info

☐ Discharge summaries

☐ Emergency event

☐ Medical info, labs, UDS results

☐ Other: n/a

1. Authorize the disclosure of information concerning diagnoses or treatment of ALCOHOL OR DRUG USE. These records are protected under Federal Regulation 42 C.F.R. Part 2, which prohibits disclosure without written consent and re-disclosure, unless otherwise provided for in Regulations.

☐ I DO

☐ I DO NOT

2. Authorize the disclosure of information concerning diagnosis or treatment of MENTAL HEALTH conditions.

☐ I DO

☐ I DO NOT

3. Authorize the disclosure of information concerning diagnosis and/or treatment of HIV INFECTION OR AIDS.

☐ I DO

☐ I DO NOT

4. Want a copy of this consent.

☐ I DO

☐ I DO NOT

Purpose of disclosure (check all that apply):

☐ Ongoing treatment/aftercare

☐ At client request

☐ Insurance authorization / billing

☐ Legal matters

☐ Coordination of services

☐ Financial matters

☐ Verification of service

☐ Emergency

☐ Other: n/a

Expiration date: From the date of signing, this authorization is effective for one year unless an earlier expiration date is indicated. I authorize future disclosures of my Crossroads records during this time period.

Earlier expiration date: n/a

I understand that I have the right to:

Review written records prior to disclosure. Refuse the disclosure of some or all health care information, but refusal for purposes of treatment, payment, or healthcare operations may result in your being denied services. Refuse to have disclosed some or all my treatment record, but that refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits / other insurance, or other adverse consequences. Revoke this authorization at any time by communicating, verbally or in writing, to any Crossroads staff, except to the extent that action has already been taken in reliance on it. I understand revocation maybe the basis for denial of health benefits or other insurance coverage or benefits. I understand that any information disclosed may potentially be re-disclosed by the recipient and no longer protected by Federal or State law.

## Rogerios Check consents

**Form Name:**
Rogerios Check consents

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

My Bed: East 4-D

# EMR-26567 Melissa Consent

**Form Name:**
EMR-26567 Melissa Consent

**Form Type:**
pre_admission

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

Data Fields

East 4-D, Shane James Export, DBH2025-24, , 10/25/2000, male, 24, 123-12-3123, 10/15/2025,123 East St

Werst, NE 34353

United States, test@test.com, 1-231-231-23123, Residential Updated -#10 , Male, F11.40

CareFirst BCBS - DB National Capital Area, Test Payor, CareFirst BCBS - DB National Capital Area Policy 12312312, Test Payor Policy 123123123,

QA Master, 123 Test Street, Miami, FL, 33139, 786-555-9999, , Miami-Dade

Locations fields will default to the corresponding company fields if the patient does not have a location assigned:

Demo Behavioral Health Center TM1, 1 Main Street, Phoenix, AZ, 00000, 210-123-456-7890, 210-098-7654,

Form Fields

n/a spouse n/a

n/a

n/a ☑ ☐ ☐Yes ☐No n/a

## consent1portal

**Form Name:**
consent1portal

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

# Transportation Form - Adolescents_shambhvee

**Form Name:**
Transportation Form - Adolescents_shambhvee

**Form Type:**
pre_admission

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

## Demo Behavioral Health Center TM1

GUIDELIGHT HEALTH

Partial Hospitalization and Intensive Outpatient Programs

Transportation Form for Adolescents

Shane James Export

10/25/2000

How will adolescent be getting to and from the program each day. Please check off and complete all applicable options.

Parent/Guardian Drop off/Pick Up (Preferred) Expectation with Drop off/Pick up is for the individual to be accompanied into the waiting room until staff accompanies the individual into group. Who will this be: Phone number: Alternative Adult for Transportation to and from program: Individual must be Adult 18+ designated by Parent/Guardian — Release of information needs to be signed for person. Expectations same as Parent/Guardian Drop off/Pick up. Parent/Guardian are expected to inform the staff in advance, and the designated adult will be required to show a valid photo ID daily for verification purposes. Who will this be: Relationship to adolescent: Release of information obtained for this person Clinician Initial: PTI — Site Approval Required. Please be aware that there must be full primary or secondary MassHealth Behavioral Health insurance coverage to qualify for the PT-1 services. This is a service provided by MassHealth. Program is not responsible for this mode of transportation other than verifying that client is attending the program. Detailed information about setting up PT1 ride will be provided. Please keep in mind PT1 transport can be unreliable; therefore, please make sure to have a backup plan if PT1 does not show up Who will this be: Relationship to adolescent Release of information obtained for this person: Yes or No Clinician Initials I, (parent/guardian) authorize the client to travel without escort, to and from the Partial Hospitalization and IOP Programs via PT1 Transport. Walking/ Public Transportation 13+ Parent/Guardian responsibility that adolescents must be in the waiting room at time of start of the program. Cab/Uber/Lyft Transport — Must have adult accompany minor per Massachusetts regulations Coordinated by parents/guardian. Parent/Guardian responsibility that adolescent must be in waiting room at time of start of program. Driving self to program — Copy of Valid License Required and Car keys will be collected. Parent/Guardian responsibility that adolescent must be in waiting room at time of start of program. Copy of License should be copied for chart. Clinician Initial Copy Obtained Other: Community Services, DCF, School Transport, etc... Expectations same as Parent/Guardian Drop off/Pick up Who will this be: Agency: Relationship to Adolescent: Release of information obtained for this person: Clinician Initial:

*Please Note: Virtual PHP is also an option to discuss with your clinician*

Understand the Clinical team assesses client daily, if clinical presentation changes and clinical team has concerns client’s being transported to and from program by PT1 might not be possible. Parent/ Guardian will be informed to make other arrangements for drop off/pick up.

Client Signature:

Date:

Parent/Guardian Name:

Date:

Parent/Guardian Signature:

Date:

Clinical Team Approval

*Clinical Team will determine based on clinical presentation if adolescent is able to be transported by an alternative to Parent/Guardian drop off/pick up. Form should be updated if clinical presentation changes determining this mode of transportation is no longer appropriate.

Clinical Team Signature:

Date of Approval:

Clinical Team Member:

Updated: 10/18/2024

Regulations around minors on Uber in Massachusetts

In Massachusetts, Uber does not allow minors under the age of 18 to ride without being accompanied by an adult. All riders must be at least 18 years of age to have an Uber account and order a ride. Users between the ages of 13 and 17 must have a parent or guardian's permission to create an Uber account. Additionally, riders under the age of 18 must be accompanied by an adult 21 years of age or older. The adult must be present in the vehicle with the minor during the entire ride.

Regulations around minors taking a taxi in Massachusetts

In Massachusetts, minors under the age of 18 are not allowed to ride alone in a taxi. All riders must be at least 18 years of age to ride in a taxi. Users between the ages of 13 and 17 must have a parent or guardian's permission to ride in a taxi. Additionally, riders under the age of 18 must be accompanied by an adult 21 years of age or older. The adult must be present in the vehicle with the minor during the entire ride.

Reference - Massachusetts Department of Public Health website, which has information on regulations for Uber and taxi services in

Massachusetts.

PT-1 Transportation Information

If you have elected to receive transportation services through PT-1 please read the following:

You must schedule your rides at least 48 hours before your appointment. On occasion, you can set up next day rides, but this is not their policy. To check your area's PTI vendor, call Masshealth at 1-800-841-2900 At the first menu select option 1 Then select #1 for English or #2 for Spanish Select #1 to enter Masshealth# —or- Select #2 to enter SSI # -or- Select #3 for a non-member Provide Address for Clinic.

If Guidelight Health you are attending the Guidelight Health the morning pick up time should be scheduled for 30 minutes before the program starts [program starts atfor adolescent andfor adults] and the evening pick up time should be scheduled for 15 minutes prior: for adolescents or for adults.

You can only be picked up at your home address and Guidelight Health, if not it will not be approved.

You may schedule multiple days at a time, but you must always call to cancel your rides if you do not need them for that day.

If you miss multiple pick-ups all your future scheduled rides may be cancelled by PT1.

Please note that you have to wait up to 30 minutes after your scheduled pick-up time for your cab to arrive.

We urge you to ask for a business card & telephone number from your driver. This is so you have a direct number to call if any issues arise.

**To file complaints such as late rides or problems with the drive please call Masshealth Directly. You cannot be retaliated against for filing a grievance. Calling to make complaints can only result in improved service in the future!

# consent1portal

**Form Name:**
consent1portal

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

este docuemnto esta compartido

# ENTENTE DE SERVICES

**Form Name:**
ENTENTE DE SERVICES

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

## ENTENTE DE SERVICES

ENTENTE DE SERVICES INTERVENUE, à Ville Mont-Royal

ENTRE:

CENTRE DE RÉADAPTION EN DÉPENDANCE DU NOUVEAU DÉPART INC., utilisant le nom « CLINIQUE NOUVEAU

DÉPART », société dûment constituée, ayant son siège social au 1110 avenue Beaumont, Ville Mont-Royal, Province de Québec, H3P 3E5, ici représentée par tet, dûment autorisé(e), ci-après désignée la « CLINIQUE »

ET :

Shane James Export

test

ci-après désigné(e) le « CLIENT »

ET :

test

ci-après désigné(e) le« LE RÉPONDANT/CAUTION »

LES PARTIES CONVIENNENT DE CE QUI SUIT :

1. LES SERVICES :

Ne sont pas visés par la présente entente les services médicaux assurés en vertu des dispositions de la Loi sur l'assurance maladie (L.R.Q., c. A-29); Les services offerts aux clients par la CLINIQUE, le Programme test, débutent le n/a pour une durée prévue de test jours et sont dispensés au centre;

2. LA RÉMUNÉRATION

En contrepartie des services à être dispensés par la Clinique, le CLIENT s'engage à payer une somme totale évaluée à test $ en entier le jour de son admission à la CLINIQUE; Tout montant impayé aux dates prévues et s'il y a lieu,

aux frais additionnels de la présente entente, portent intérêt dès l'échéance, sans nécessité de mise en demeure, au taux de 24% l'an soit 2% par mois; Tout montant dû conformément à la présente entente est payable à l'ordre de la CLINIQUE.

3. FRAIS ADDITIONNELS

Le CLIENT reconnaît, par la présente entente, être responsable du paiement des déboursés encourus par la CLINIQUE; Advenant le cas où l'état du CLIENT exigerait un service infirmier privé lors de son hébergement, le CLIENT s'engage à défrayer les coûts de ce service, sur présentation de pièces justificatives; Advenant le cas où le CLIENT décide d'extensionner son programme, un coût quotidien additionnel est à prévoir.

4. RESPONSABILITÉ

Le CLIENT reconnaît, par la présente entente, que les obligations de la CLINIQUE sont des obligations de moyen et que cette dernière ne peut garantir les résultats des interventions auprès du CLIENT; Dans l'éventualité où le CLIENT présenterait lors de son séjour à la CLINIQUE des signes d'intoxication, il autorise expressément la CLINIQUE à prendre des dispositions visant notamment à l'empêcher de conduire un véhicule automobile, et d'en aviser les autorités; Le paragraphe précédent ne constitue pas une obligation imposée à la CLINIQUE, qui peut choisir de ne pas intervenir. Le CLIENT s'engage à indemniser la CLINIQUE pour tout dommage résultant d'une faute de sa part lors d'un séjour à la CLINIQUE; En aucun cas, la CLINIQUE peut être tenue responsable des objets perdus ou volés lors de la présence du CLIENT dans l'établissement, dans le stationnement ou sur les terrains avoisinants;

5. LOI APPLICABLE ET JURIDICTION

J'accepte, par la présente, que la relation entre moi-même et le médecin traitant et le règlement de tout différend qu'elle pourra susciter, soient régis par les lois de la province de Québec et interprétés en fonction de celles-ci. Je reconnais par la présente que le traitement sera prodigué dans la province de Québec et que les cours de la province de Québec auront juridiction pour recevoir toute plainte, demande, réclamation ou cause d'action, que celle-ci soit fondée sur une présumée rupture de contrat ou une présumée négligence consécutive au traitement. Je conviens par la présente qui si j'entame de telles procédures judiciaires, ce sera uniquement dans la province de Québec; je m'en remets irrévocablement, par la présente, à la juridiction exclusive des cours de la province de Québec.

6. FIN DE L'ENTENTE

Si le CLIENT désire mettre fin à l'entente de façon prématurée, des frais d'annulation de 10% des frais du programme en entier seront imposés; Le prorata des journées non-utilisées du programme sera remboursé; Pour mettre fin à la présente entente, le CLIENT doi donner un avis écrit à cet effet à la CLINIQUE en signant le formulaire de résiliation; L'entente est résiliée de plein droit à compter de l'avis de résiliation approuvé par le directeur général de la CLINIQUE.

7. NULLITÉ D'UNE CLAUSE

La nullité ou la non-exécution d'une clause de la présente entente n'affecte en rien les autres dispositions, leur validité ou leur force exécutoire. Les clauses, à ce titre, s'interprétant séparément;

8. ÉLECTION DE DOMICILE

Toute procédure judiciaire relative à l'entente devra être intentée dans la province de Québec devant le tribunal ayant compétence dans le district judiciaire de Montréal.

9. En foi de quoi, je reconnais avoir lu et compris le sens de cette et être en accord avec son contenu. SIGNÉ à Ville Mont-Royal, ce test,

Dépôt de réservation : En tant que patient et/ou payeur, je comprends que le dépôt non remboursable de 500 $ est requis pour conserver la date d'admission du test pour le traitement. Le dépôt non remboursable est applicable sur le solde du soin s'il est utilisé dans les 12 mois. Lors de l’admission, le dépôt non remboursable sera appliqué au dépôt de médicaments ou au premier paiement.

J'accepte : ☐ Oui ☑ N'est pas applicable

# shambhvee_consent

**Form Name:**
shambhvee_consent

**Form Type:**
pre_admission

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

data_field.patient.bed], Shane James Export, DBH2025-24, , 10/25/2000, male, 24, 123-12-3123, 10/15/2025,123 East St

Werst, NE 34353

United States, test@test.com, 1-231-231-23123, Residential Updated -#10 , Male, F11.40

CareFirst BCBS - DB National Capital Area, Test Payor, CareFirst BCBS - DB National Capital Area Policy 12312312, Test Payor Policy 123123123,

QA Master, 123 Test Street, Miami, FL, 33139, 786-555-9999, , Miami-Dade

Locations fields will default to the corresponding company fields if the patient does not have a location assigned:

Demo Behavioral Health Center TM1, 1 Main Street, Phoenix, AZ, 00000, 210-123-456-7890, 210-098-7654,

Only for rules: For contact information with all available fields of a rule, e.g. all patient contacts, use: [data_field.rule_block]

## Form fields:

Use [form_field."name" "type"], e.g. n/a

Field types are: list, text, textarea, date, checkbox_on, checkbox_off, radio_yes_no

ALL form field names need to be unique.

The form field name "form_title" will be added automatically to the form's title.

Some of the fields allow/require a secondary parameter:

# Informed Consent for AI-Augmented Healthcare Session

**Form Name:**
Informed Consent for AI-Augmented Healthcare Session

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

## Informed Consent for AI-Augmented Healthcare Session

Thank you for considering participation in an AI-augmented session with your healthcare provider. This document aims to inform you about the nature of the session, the use of artificial intelligence (AI), and your rights as a patient. Please read this consent form carefully and ask any questions you may have before signing.

Purpose of the AI-Augmented Session

The purpose of this session is to enhance the quality of your healthcare experience using AI technology. AI tools may assist in analyzing data, providing insights, and supporting your provider's clinical decision-making process. The use of AI is intended to complement, not replace, the judgment and expertise of your healthcare provider.

2. Description of AI Use

During your session, AI technology may be used in various ways, including but not limited to:

Analyzing medical data and history to provide insights and recommendations. Assisting in identifying potential health concerns or patterns. Supporting the provider in formulating treatment plans or recommendations.

3. Data Privacy and Security

Your privacy is a top priority. AI systems used in this session are designed to comply with applicable privacy laws and regulations. The following measures are in place to protect your data:

Your personal and medical information will be stored securely and used only for the purposes of your healthcare. AI tools will not retain or use data beyond the scope of the session. Data will be anonymized and aggregated as needed to ensure confidentiality.

4. Potential Risks and Benefits

Benefits:

Improved accuracy and efficiency in analyzing medical information. Enhanced support in making informed decisions about your health. Access to advanced tools and insights that may improve your overall care.

Risks:

AI systems may not be perfect and could have limitations in understanding complex or nuanced health issues. There is a small risk of data breaches, although robust security measures are in place to mitigate this risk.

5. Your Rights and Responsibilities

Voluntary Participation: Your participation in the AI-augmented session is entirely voluntary. You may choose not to use the AI tools and still receive standard care. Informed Choice: You have the right to ask questions about the AI technology being used and how it may impact your care. Withdrawal: You may withdraw from the AI-augmented session at any time without affecting your access to standard medical services.

6. Consent

By signing this form, you acknowledge that you have read and understood the information provided, including the potential risks and benefits of participating in an AI-augmented session. You consent to the use of AI technology in your healthcare session and agree to the terms outlined above.

# ROnald Test1

**Form Name:**
ROnald Test1

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

Consent test

Consent test

Consent test

Consent test

## Allow Recording

**Form Name:**
Allow Recording

**Form Type:**
pre_admission

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

# Consent Required for Lab

**Form Name:**
Consent Required for Lab

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

## Demo Behavioral Health Center TM1

## Admission Orientation Checklist

## Name: Shane James Export MR#: DBH2025-24 DOB: 10/25/2000

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

☐ Nature and goals of program including admission and discharge criteria

☐ Consent for treatment

☑ Financial agreement and treatment costs, if any

☐ Orientation Handbook; inclusive of, but not limited to the following topics

☐ Client legal and human rights

☐ Grievance procedure

☑ Program rules and regulations

☐ Confidentiality and limitations of confidentiality

☐ Infection control procedures

☐ Therapist Assignment

☐ Treatment Schedule

☐ Urinalysis procedure and how results are utilized

☑ Fire exits and emergency evacuations procedures

☐ Emergency Services

☐ Responsibilities for participation in treatment

☐ Admission and Discharge Criteria

My signature confirms that I have engaged in an orientation process with Demo Behavioral Health Center TM1 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.

## 13.9 New Consent Form

**Form Name:**
13.9 New Consent Form

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

Patient Name goes here:

Shane James Export

# New_Consent Form_RC 13.5_RC4

**Form Name:**
New_Consent Form_RC 13.5_RC4

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

data_field.patient.bed], Shane James Export, DBH2025-24, , 10/25/2000, male, 24, 123-12-3123, 10/15/2025,123 East St

Werst, NE 34353

United States, test@test.com, 1-231-231-23123, Residential Updated -#10 , Male, F11.40

CareFirst BCBS - DB National Capital Area, Test Payor, CareFirst BCBS - DB National Capital Area Policy 12312312, Test Payor Policy 123123123,

QA Master, 123 Test Street, Miami, FL, 33139, 786-555-9999, , Miami-Dade

Locations fields will default to the corresponding company fields if the patient does not have a location assigned:

Demo Behavioral Health Center TM1, 1 Main Street, Phoenix, AZ, 00000, 210-123-456-7890, 210-098-7654,

Only for rules: For contact information with all available fields of a rule, e.g. all patient contacts, use: [data_field.rule_block]

# Confidentiality Policy - test referrer

**Form Name:**
Confidentiality Policy - test referrer

**Form Type:**
pre_admission

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

## Demo Behavioral Health Center TM1

## Confidentiality Policy

## Name: Shane James Export MR#: DBH2025-24 DOB: 10/25/2000

The following information is provided to assist you in your counseling experience at Demo Behavioral Health Center TM1.

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

We work from a team approach at Demo Behavioral Health Center TM1. 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 Demo Behavioral Health Center TM1 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.

SATISFACTION SURVEY

Your satisfaction is the key to our success. We want you to tell us what is good about our services and where we need to improve. Periodically we will distribute a satisfaction survey to you to be filled out. Your signature is optional.

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

# Confidentiality Policy_Shambhvee

**Form Name:**
Confidentiality Policy_Shambhvee

**Form Type:**
standard

**Status:**
status_complete

**Signed:**
No

**Signed By:**
N/A

**Signed At:**
N/A

**Content:**

## Demo Behavioral Health Center TM1

## Confidentiality Policy

## Name: Shane James Export MR#: DBH2025-24 DOB: 10/25/2000

The following information is provided to assist you in your counseling experience at Demo Behavioral Health Center TM1.

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

We work from a team approach at Demo Behavioral Health Center TM1. 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 Demo Behavioral Health Center TM1 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.

SATISFACTION SURVEY

Your satisfaction is the key to our success. We want you to tell us what is good about our services and where we need to improve. Periodically we will distribute a satisfaction survey to you to be filled out. Your signature is optional.

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

# Trauma Assessment

**Evaluation Name:**
Trauma Assessment

**Date:**
10/15/2025, 3:32:22 PM

**Status:**
status_complete

**Complete:**
Yes

**Tab Name:**
Pre-Admission

**Items Count:**
31

**Evaluation Items**

**Date/Time:**
Not provided

**golden_thread_tag**
None

**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?**
1 True

**Please list your traumas:**
This is some text about past traumas

**2. During the traumatic event, did you experience or witness serious injury or death, or the threat of injury or death?**
1 True

**3. During the traumatic event did you feel intense fear, helplessness, and/or horror?**
0 False

**4. Do you regularly experience intrusive thoughts or images about the traumatic event?**
1 True

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

**6. Do you have recurrent nightmares or distressing dreams about the traumatic event?**
1 True

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

**8. Do you try to avoid thoughts, feelings, or conversations that remind you of the traumatic event?**
0 False

**9. Do you try to avoid activities, people, or places that remind you of the traumatic event?**
0 False

**10. Are you unable to remember something important about the traumatic event?**
0 False

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

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

**13. Since the trauma took place, do you have difficulty experiencing or showing emotions?**
1 True

**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?**
0 False

**15. Since the traumatic event, have you had difficulty falling or staying asleep?**
0 False

**16. Have you felt irritable or have you had outbursts of anger?**
0 False

**17. Have you had difficulty concentrating, since the trauma?**
1 True

**18. Do you feel guilty because others died or were hurt during the traumatic event but you survived it?**
1 True

**19. Do you often feel jumpy or startle easily?**
1 True

**20. Do you often feel hypervigilant, that is, are you constantly feeling and acting ready for any kind of threat?**
0 False

**21. Have you been experiencing symptoms for more than one month?**
1 True

**22. Do your symptoms interfere with normal routines, work or school, or social activities?**
0 False

**23. Do your symptoms interfere with ability to stay sober/clean?**
1 True

**Score**
NAR:: field_type: points_total

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)**
This is lengthy clinical assessment. I might be in here typing for half the day and then I'll get mad when my machine closes and I haven't clicked out without saving.

# 3135 EVAL Anc Ins CCode

**Evaluation Name:**
3135 EVAL Anc Ins CCode

**Date:**
10/16/2025, 11:54:00 AM

**Status:**
status_ready_for_review

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:00 AM

## 13.9 Evaluation Form

**Evaluation Name:**
13.9 Evaluation Form

**Date:**
10/16/2025, 11:54:30 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**evaluation_name**
NAR:: field_type: evaluation_name

# 53+ min: OP Individual Progress Note (SBC)

**Evaluation Name:**
53+ min: OP Individual Progress Note (SBC)

**Date:**
10/16/2025, 11:54:31 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

**Evaluation Items**

**Date/Time of Service**
10/16/2025, 11:54:31 AM

# 3165 EVAL NonAnc Prof

**Evaluation Name:**
3165 EVAL NonAnc Prof

**Date:**
10/16/2025, 11:54:31 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:31 AM

**text**
Not provided

# Abhinav script

**Evaluation Name:**
Abhinav script

**Date:**
10/16/2025, 11:54:31 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**auto_complete**
NAR:: field_type: auto_complete

# Added Ancillary & Billable Evaluation

**Evaluation Name:**
Added Ancillary & Billable Evaluation

**Date:**
10/16/2025, 11:54:32 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**text**
Not provided

**text**
Not provided

# Automation - Billable and Ancillary w MISC codes

**Evaluation Name:**
Automation - Billable and Ancillary w MISC codes

**Date:**
10/16/2025, 11:54:32 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:32 AM

## BillableDiagnosisEvaluation

**Evaluation Name:**
BillableDiagnosisEvaluation

**Date:**
10/16/2025, 11:54:33 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**Diagnosis**
F11.40

**Start and End Time**
10/16/2025, 11:54:33 AM

## BillingEvaluationOverlappingAttendance

**Evaluation Name:**
BillingEvaluationOverlappingAttendance

**Complete:**
No

**Date:**
10/16/2025, 11:54:33 AM

**Tab Name:**
Evaluations

**Status:**
status_empty

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:33 AM

**text**
Not provided

## BillingEvaluationOverlappingInPatRdOff

**Evaluation Name:**
BillingEvaluationOverlappingInPatRdOff

**Date:**
10/16/2025, 11:54:33 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:33 AM

**text**
Not provided

## BillingEvaluationOverlappingInPatRdON

**Evaluation Name:**
BillingEvaluationOverlappingInPatRdON

**Date:**
10/16/2025, 11:54:34 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:34 AM

**text**
Not provided

# 1141_eval - import Physician

**Evaluation Name:**
1141_eval - import Physician

**Date:**
10/16/2025, 11:54:00 AM

**Status:**
status_complete

**Complete:**
Yes

**Tab Name:**
Evaluations

**Items Count:**
36

### Evaluation Items

**patient.anticipated_discharge_date**
10/31/2025, 3:00:00 AM

**BedName**
East 4-D

**eval_name**
NAR:: field_type: evaluation_name

**evaluation_start_and_end_time**
10/16/2025, 11:54:00 AM

**notes**
Not provided

**AdmissionDate**
Not provided

**Height_Weight**
Not provided

**patient.marital_status**
Divorced

**Locker**
123

**employer name**
Not provided

**ethnicity**
Cuban

**patient.ciwa_ar**
Not provided

**patient.cows**
{

"id": 2093,
"patient_id": 16096,
"pulse_rate": null,
"sweating": null,
"restlessness": null,
"pupil_size": null,
"bone_joint_ache": null,
"runny_nose": null,
"gi_upset": null,
"tremor": null,
"yawning": null,
"anxiety_irritability": null,
"gooseflesh_skin": null,
"username": null,
"interval": null,
"created_at": "2025-10-15T12:31:11.465-07:00",
"updated_at": "2025-10-15T12:31:11.465-07:00",
"status": "empty",
"record_source": null,
"deleted_by": null,
"deleted_at": null
}, {
"id": 2097,
"patient_id": 16096,
"pulse_rate": null,
"sweating": null,
"restlessness": null,
"pupil_size": null,
"bone_joint_ache": null,
"runny_nose": null,
"gi_upset": null,
"tremor": null,
"yawning": null,
"anxiety_irritability": null,
"gooseflesh_skin": null,
"username": null,
"interval": null,
"created_at": "2025-10-16T08:55:15.375-07:00",
"updated_at": "2025-10-16T08:55:15.375-07:00",
"status": "empty",
"record_source": null,
"deleted_by": null,
"deleted_at": null
}, {
"id": 2096,
"patient_id": 16096,
"pulse_rate": null,
"sweating": null,
"restlessness": null,
"pupil_size": null,
"bone_joint_ache": null,
"runny_nose": null,

"gi_upset": null,
"tremor": null,
"yawning": null,
"anxiety_irritability": null,
"gooseflesh_skin": null,
"username": "Shane Carroll, Product Manager",
"interval": "2025-10-16T09:14:00.000-07:00",
"created_at": "2025-10-16T08:54:29.912-07:00",
"updated_at": "2025-10-16T09:15:39.041-07:00",
"status": "empty",
"record_source": "PatientEvaluationItem",
"deleted_by": null,
"deleted_at": null
}, {
"id": 2095,
"patient_id": 16096,
"pulse_rate": 1,
"sweating": 2,
"restlessness": 1,
"pupil_size": 2,
"bone_joint_ache": 0,
"runny_nose": 0,
"gi_upset": 0,
"tremor": 1,
"yawning": 0,
"anxiety_irritability": 1,
"gooseflesh_skin": 0,
"username": "Shane Carroll, Product Manager",
"interval": "2025-10-16T08:46:00.000-07:00",
"created_at": "2025-10-16T08:46:57.643-07:00",
"updated_at": "2025-10-16T08:46:57.643-07:00",
"status": "active",
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null
}, {
"id": 2094,
"patient_id": 16096,
"pulse_rate": 1,
"sweating": 1,
"restlessness": 1,
"pupil_size": 1,
"bone_joint_ache": 1,
"runny_nose": 1,
"gi_upset": 1,
"tremor": 1,
"yawning": 1,
"anxiety_irritability": 1,
"gooseflesh_skin": 3,
"username": "Shane Carroll, Product Manager",
"interval": "2025-10-16T07:27:00.000-07:00",
"created_at": "2025-10-16T07:27:42.222-07:00",

"updated_at": "2025-10-16T07:27:42.222-07:00",
"status": "active",
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null
}

**CIWA_B**
Not provided

**Vital_sign**
{
"id": 5456,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:55:15.101-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": null,
"created_at": "2025-10-16T08:55:15.392-07:00",
"updated_at": "2025-10-16T08:55:15.392-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": null,
"deleted_by": null,
"deleted_at": null,
"comments": null
}, {
"id": 5455,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:54:50.839-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": null,
"created_at": "2025-10-16T08:54:52.719-07:00",
"updated_at": "2025-10-16T08:54:52.719-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": null,
"deleted_by": null,
"deleted_at": null,
"comments": null
}, {
"id": 5454,
"patient_id": 16096,

"interval_timestamp": "2025-10-16T08:54:00.000-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": "Shane Carroll, Product Manager ",
"created_at": "2025-10-16T08:54:29.947-07:00",
"updated_at": "2025-10-16T09:12:13.310-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientEvaluationItem",
"deleted_by": null,
"deleted_at": null,
"comments": ""
}, {
"id": 5453,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:45:00.000-07:00",
"blood_pressure_systolic": 110,
"blood_pressure_diastolic": 80,
"temperature": "94.0",
"pulse": 188,
"respirations": 10,
"user_name": "Shane Carroll, Product Manager",
"created_at": "2025-10-16T08:45:49.604-07:00",
"updated_at": "2025-10-16T08:45:49.604-07:00",
"o2_saturation": 80,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null,
"comments": ""
}, {
"id": 5452,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T07:26:00.000-07:00",
"blood_pressure_systolic": 120,
"blood_pressure_diastolic": 80,
"temperature": "98.0",
"pulse": 100,
"respirations": 14,
"user_name": "Shane Carroll, Product Manager",
"created_at": "2025-10-16T07:26:47.433-07:00",
"updated_at": "2025-10-16T07:26:47.433-07:00",
"o2_saturation": 99,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientChart",
"deleted_by": null,

"deleted_at": null,
"comments": ""
}

**Glucose_log**
Not provided

**Ortho Sign**
Not provided

**attachment**
NAR:: field_type: attachments

**evaluation_date**
10/16/2025, 11:54:00 AM

**evaluation_datetime**
10/16/2025, 11:54:00 AM

**checkbox**
None

**checkbox**
None

**checkbox_none**
None

**DropDownList**

**DropDownList**

**radio_button**

**eval_date**
10/16/2025, 11:54:00 AM

**eval_date_time**
10/16/2025, 11:54:00 AM

**Service Provided by:**
NAR:: field_type: evaluation_name_drop_down

**matrix**
None

**string**

**Text**

**PMP Query:**

**electronic Dev**
None

**electronic Dev2**
None

**Start/End time**
10/16/2025, 11:54:00 AM

## BillingEvaluationOverlappingOutPatient

**Evaluation Name:**
BillingEvaluationOverlappingOutPatient

**Date:**
10/16/2025, 11:54:34 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:34 AM

**text**
Not provided

# Chini | Testing Auto Code by Duration

**Evaluation Name:**
Chini | Testing Auto Code by Duration

**Date:**
10/16/2025, 11:54:35 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:35 AM

# billingQAT2919

**Evaluation Name:**
billingQAT2919

**Date:**
10/16/2025, 11:54:34 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
3

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:34 AM

**text**
Not provided

**Test Field**
NAR:: field_type: conditional_question

# Custom Prompt field

**Evaluation Name:**
Custom Prompt field

**Date:**
10/16/2025, 11:54:35 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

### Evaluation Items

**text**
Not provided

**string**

**text**
Not provided

**string**

# Chini | Billable Evaluation

**Evaluation Name:**
Chini | Billable Evaluation

**Date:**
10/16/2025, 11:54:35 AM

**Status:**
no_signature_requirement

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:35 AM

## Current form

**Evaluation Name:**
Current form

**Date:**
10/16/2025, 11:54:35 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
3

### Evaluation Items

**Meds**
Not provided

**text**
Not provided

**string**

# Discharge DT

**Evaluation Name:**
Discharge DT

**Date:**
10/16/2025, 11:54:36 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
5

### Evaluation Items

**Check box**
None

**Date**
10/16/2025, 11:54:36 AM

**evaluation_start_and_end_time**
10/16/2025, 11:54:36 AM

**patient.discharge_type**
Not provided

**Bed**
East 4-D

# Eval_Discharge type not getting save_EMR-5487 - import

**Evaluation Name:**
Eval_Discharge type not getting save_EMR-5487 - import

**Date:**
10/16/2025, 11:54:36 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

**Evaluation Items**

**Date Time**
10/16/2025, 11:54:36 AM

**Discharge Type**
Not provided

# Eval QAT-3137

**Evaluation Name:**
Eval QAT-3137

**Date:**
10/16/2025, 11:54:37 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
0

**Evaluation Items**

# EMR-15451:Evaluations: Start/End Time fieldtype:Shambhvee

**Evaluation Name:**
EMR-15451:Evaluations: Start/End Time fieldtype:Shambhvee

**Date:**
10/16/2025, 11:54:36 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

**Evaluation Items**

**Start/End Time**
10/16/2025, 11:54:36 AM

**Notes**
Not provided

**Care Team**
NAR:: field_type: care_team.Primary_Physician

**28980**
F11.40

# Evaluation Title Form - regression

**Evaluation Name:**
Evaluation Title Form - regression

**Date:**
10/16/2025, 11:54:37 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
0

**Evaluation Items**

# EVALQAT3294

**Evaluation Name:**
EVALQAT3294

**Date:**
10/16/2025, 11:54:37 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:37 AM

**text**
Not provided

# first

**Evaluation Name:**
first

**Date:**
10/16/2025, 11:54:38 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:38 AM

**text**
Not provided

# Follow Up Therapy Progress Note - import

**Evaluation Name:**
Follow Up Therapy Progress Note - import

**Date:**
10/16/2025, 11:54:39 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
49

**Evaluation Items**

**Date:**
10/16/2025, 11:54:39 AM

**Level of Care**
Not provided

**Start and End Time**
10/16/2025, 11:54:39 AM

**Did the client attend the session?**

**Subjective (Client's subjective reporting of symptoms/problems and therapist's observation and opinions):**
Not provided

**Objective (Quantifiable, factual, and measurable data):**

**Sleep/hrs:**

**Appetite:**

**Depression:**

**Anxiety:**

**Impulsivity:**

**Adherence to medication regimen:**

**Any medication updates?**

**If yes, describe:**
Not provided

**Mental Status Examination:**

**OBSERVATIONS**

**Appearance**
None

**Speech**
None

**Eye Contact**
None

**Motor Activity**
None

**Affect**
None

**Comments:**
Not provided

**Mood**

**check_box**
None

**Comments:**
Not provided

**Cognition**

**Orientation Impairment**
None

**Memory Impairment**
None

**Attention**
None

**Comments:**
Not provided

**Perception**

**Hallucinations**
None

**Other**
None

**Comments:**
Not provided

**Thoughts**

**Suicidality**
None

**If the client indicates suicidal ideation, plan, and/or intent, proceed to completing the C-SSRS short version.**

**Homicidality**
None

**Delusions**
None

**Comments:**
Not provided

**Behavior**

**check_box**
None

**Comments:**
Not provided

**Insight**
None

**Judgment**
None

**Assessment/Medical Necessity (What symptoms/factors are preventing the client from discharging to a lower level of care?):**
Not provided

**Describe the progress achieved in treatment thus far:**
Not provided

**Plan (What evidence-based interventions are we using and how are we addressing the treatment goals?):**
Not provided

**golden_thread_tag**
None

# Joe Billable Auto pick code (time duration) EMR-14275 _shambhvee

**Evaluation Name:**
Joe Billable Auto pick code (time duration) EMR-14275 _shambhvee

**Date:**
10/16/2025, 11:54:41 AM

**Status:**
no_signature_requirement

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

## Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:41 AM

**Care team**
NAR:: field_type: care_team.Primary_Provider

# FT Non Ancillary

**Evaluation Name:**
FT Non Ancillary

**Date:**
10/16/2025, 11:54:40 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:40 AM

# FT Ancillary

**Evaluation Name:**
FT Ancillary

**Date:**
10/16/2025, 11:54:40 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**text**
Not provided

**patient.recurring_forms**
Not provided

# Hassan's New Eval

**Evaluation Name:**
Hassan's New Eval

**Date:**
10/16/2025, 11:54:40 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**Weight**
Not provided

# Manage Diagnosis Code (old)

**Evaluation Name:**
Manage Diagnosis Code (old)

**Date:**
10/16/2025, 11:54:41 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
3

## Evaluation Items

**Todays Date**
10/16/2025, 11:54:41 AM

**Patient Diagnosis**
F11.40

**Comments**
Not provided

# Marie Test

**Evaluation Name:**
Marie Test

**Date:**
10/16/2025, 11:54:41 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

### Evaluation Items

**formatted_text**
CareFirst BCBS - DB National Capital Area Policy 12312312, Test Payor Policy 123123123

**Dynamic Testing**
NAR:: field_type: dynamic_matrix

**TEST**
Not provided

**care_team.Primary_Therapist**
NAR:: field_type: care_team.Primary_Therapist

# Milo Evaluation - Clinical Provider

**Evaluation Name:**
Milo Evaluation - Clinical Provider

**Date:**
10/16/2025, 11:54:43 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:43 AM

# MON Tech Personal Property Returned - import

**Evaluation Name:**
MON Tech Personal Property Returned - import

**Date:**
10/16/2025, 11:54:43 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
3

**Evaluation Items**

**Date:**
10/16/2025, 11:54:43 AM

**Personal Property Items:**
Not provided

**formatted_text**
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. © 2012-2021 Kipu Systems LLC

## MyChartNewEvaluationName

**Evaluation Name:**
MyChartNewEvaluationName

**Date:**
10/16/2025, 11:54:43 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
0

**Evaluation Items**

## NewBillingEvaluationName

**Evaluation Name:**
NewBillingEvaluationName

**Date:**
10/16/2025, 11:54:43 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
0

**Evaluation Items**

## NewBillingEvaluationOverlapping

**Evaluation Name:**
NewBillingEvaluationOverlapping

**Date:**
10/16/2025, 11:54:44 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**Start and End Time**
10/16/2025, 11:54:44 AM

# New Evalation Template after code fix for the bug RC 13.5 Rc4

**Evaluation Name:**
New Evalation Template after code fix for the bug RC 13.5 Rc4

**Date:**
10/16/2025, 11:54:44 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

**Evaluation Items**

**Text**
Not provided

**Name**
NAR:: field_type: evaluation_name

**Time**
10/16/2025, 11:54:44 AM

**Title**

# QAT2862Eval

**Evaluation Name:**
QAT2862Eval

**Date:**
10/16/2025, 11:54:46 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:46 AM

**text**
Not provided

# QAT3154Eval

**Evaluation Name:**
QAT3154Eval

**Date:**
10/16/2025, 11:54:47 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:47 AM

**text**
Not provided

# NewEval_Template1

**Evaluation Name:**
NewEval_Template1

**Date:**
10/16/2025, 11:54:44 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**Unlabeled Field**
NAR:: field_type:

# new KTS eval

**Evaluation Name:**
new KTS eval

**Date:**
10/16/2025, 11:54:45 AM

**Status:**
no_signature_requirement

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

**Evaluation Items**

**Unlabeled Field**

# QAT3153Eval

**Evaluation Name:**
QAT3153Eval

**Date:**
10/16/2025, 11:54:46 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:46 AM

**text**
Not provided

# QAT3155Eval

**Evaluation Name:**
QAT3155Eval

**Date:**
10/16/2025, 11:54:47 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:47 AM

**text**
Not provided

## NewTestEvaluation_1

**Evaluation Name:**
NewTestEvaluation_1

**Date:**
10/16/2025, 11:54:45 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**Unlabeled Field**
NAR:: field_type:

# QAT3152Eval

**Evaluation Name:**
QAT3152Eval

**Date:**
10/16/2025, 11:54:46 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:46 AM

**text**
Not provided

# QAT3156Eval

**Evaluation Name:**
QAT3156Eval

**Date:**
10/16/2025, 11:54:47 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:47 AM

**text**
Not provided

# QAT3165Eval

**Evaluation Name:**
QAT3165Eval

**Date:**
10/16/2025, 11:54:48 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:48 AM

**text**
Not provided

# QAT3290Eval

**Evaluation Name:**
QAT3290Eval

**Date:**
10/16/2025, 11:54:48 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:48 AM

**text**
Not provided

# Quick text

**Evaluation Name:**
Quick text

**Date:**
10/16/2025, 11:54:48 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**Text**
Not provided

# RevisionRequired

**Evaluation Name:**
RevisionRequired

**Date:**
10/16/2025, 11:54:48 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**Test**
Not provided

**Test2**
Not provided

## second

**Evaluation Name:**
second

**Date:**
10/16/2025, 11:54:49 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:49 AM

**text**
Not provided

# Shambhvee/eval//pdfcheck11///01\\\\undefined method `mat_medication' for #<Patient:0x00007f84341ac5b0>

**Evaluation Name:**
Shambhvee/eval//pdfcheck11///01\\\\undefined method `mat_medication' for #<Patient:0x00007f84341ac5b0>

**Date:**
10/16/2025, 11:54:50 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

## Evaluation Items

**text**
Not provided

**evaluation_date**
10/16/2025, 11:54:50 AM

# Ronald Evaluation

**Evaluation Name:**
Ronald Evaluation

**Date:**
10/16/2025, 11:54:48 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

### Evaluation Items

**attachments**
NAR:: field_type: attachments

**care_team.Disabled**
NAR:: field_type: care_team.Disabled

**care_team.Primary_Physician**
NAR:: field_type: care_team.Primary_Physician

**create_evaluation**
NAR:: field_type: create_evaluation

# Shambhvee_eval_02\undefined method _mat_medication'\for eval

**Evaluation Name:**
Shambhvee_eval_02\undefined method _mat_medication'\for eval

**Date:**
10/16/2025, 11:54:49 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

## Evaluation Items

**eval**
Not provided

**eval02**
Not provided

# Script Testing Abhi

**Evaluation Name:**
Script Testing Abhi

**Date:**
10/16/2025, 11:54:49 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**auto_complete**
NAR:: field_type: auto_complete

## Shambhvee_Evaluation D

**Evaluation Name:**
Shambhvee_Evaluation D

**Date:**
10/16/2025, 11:54:50 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**time**
10/16/2025, 11:54:50 AM

**Care team**
NAR:: field_type: care_team.Primary_Therapist

# Shambhvee_New_eval_04112024_13.5_RC4

**Evaluation Name:**
Shambhvee_New_eval_04112024_13.5_RC4

**Date:**
10/16/2025, 11:54:52 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
62

## Evaluation Items

**treatment_plan_problem**

**treatment_plan_column_titles**
NAR:: field_type: treatment_plan_column_titles

**treatment_plan_item**
NAR:: field_type: treatment_plan_item

**treatment_plan_item**
NAR:: field_type: treatment_plan_item

**treatment_plan_objective**
NAR:: field_type: treatment_plan_objective

**Title here**

**care_team.Auditor_J**
NAR:: field_type: care_team.Auditor_J

**care_team.Case_Manager**
NAR:: field_type: care_team.Case_Manager

**care_team.Deleted_Optional**
NAR:: field_type: care_team.Deleted_Optional

**care_team.Disabled**
NAR:: field_type: care_team.Disabled

**care_team.Option_fc**
NAR:: field_type: care_team.Option_fc

**care_team.Primary_Nurse**
NAR:: field_type: care_team.Primary_Nurse

**care_team.Primary_Physician**
NAR:: field_type: care_team.Primary_Physician

**care_team.Primary_Provider**

NAR:: field_type: care_team.Primary_Provider

**care_team.Primary_Spiritual_Advisor**
NAR:: field_type: care_team.Primary_Spiritual_Advisor

**care_team.Primary_Therapist**
NAR:: field_type: care_team.Primary_Therapist

**check_box**
None

**check_box_first_value_none**
None

**datestamp**
Invalid Date

**conditional_question**
NAR:: field_type: conditional_question

**create_evaluation**
NAR:: field_type: create_evaluation

**datestamp**
Invalid Date

**drop_down_list**

**evaluation_date**
10/16/2025, 11:54:52 AM

**evaluation_datetime**
10/16/2025, 11:54:52 AM

**evaluation_name**
NAR:: field_type: evaluation_name

**evaluation_start_and_end_time**
10/16/2025, 11:54:52 AM

**notes**
Not provided

**formatted_text**

**patient.glucose_log**
Not provided

**patient.height_weight**
Not provided

**patient.height_weight_current**
Not provided

**rounds_assignment**
NAR:: field_type: rounds_assignment

**points_total**
NAR:: field_type: points_total

**patient.discharge_medications**
Not provided

**patient.allergies**
{
"id": 6629,
"patient_id": 16096,
"allergen": "Pollen",
"reaction": "Hives",
"treatment": "",
"created_at": "2025-10-15T12:28:36.309-07:00",
"updated_at": "2025-10-15T12:28:55.820-07:00",
"created_by": "Shane Carroll, Product Manager",
"updated_by": "Shane Carroll, Product Manager",
"allergy_type": "other",
"deleted": false,
"deleted_at": null,
"deleted_by": null,
"onset": null,
"reaction_type": "Allergy",
"status_type": "Active",
"source": "",
"dose_spot_code": "",
"dose_spot_allergy_id": null,
"show_on_wristband": false,
"dose_spot_code_type": "",
"allergen_id": null,
"allergy_severity_id": null,
"rcopia_id": null
}

**patient.attendances**
{
"id": 16096,
"first_name": "Shane",
"middle_name": "James",
"last_name": "Export",
"encrypted_dob": "SbpbR6XJk2Sg1Lxgq+kVhg==\n",
"encrypted_ssn": "98hQXQ1F0m65nJtrisBaoA==\n",
"gender": "male",
"marital_status": "Divorced",
"address_street": "123 East St",
"address_street2": "",

"address_city": "Werst",
"address_zip": "34353",
"address_state": "NE",
"address_country": "United States",
"occupation": "Product Manager",
"employer_name": "Kipu Health",
"employer_phone": "",
"created_at": "2025-10-15T10:59:40.367-07:00",
"updated_at": "2025-10-16T09:24:58.766-07:00",
"image_file_name": null,
"image_content_type": null,
"image_file_size": null,
"image_updated_at": null,
"mr": "DBH2025-24",
"payment_method": "Insurance",
"payment_method_id": null,
"patient_id_image_file_name": null,
"patient_id_image_content_type": null,
"patient_id_image_file_size": null,
"patient_id_image_updated_at": null,
"food_restrictions": "",
"deleted": false,
"validated": false,
"has_insurance": true,
"phone": "1-231-231-23123",
"alternate_phone": "1-231-231-2312",
"one_time_only_patient": false,
"bed_name": "East 4-D",
"has_no_allergy": false,
"weight": "110.0",
"height": "69.0",
"has_no_inventory": false,
"recurring_status": false,
"status": null,
"locker": "123",
"discharge_date": null,
"admission_date": "2025-10-15T11:00:00.000-07:00",
"ssn_created_at": "2025-10-15T12:26:06.983-07:00",
"race": "American Indian/Alaska Native",
"ethnicity": "Cuban",
"email": "test@test.com",
"allow_utilization_review": false,
"pre_admission_status": "1st Contact ",
"patient_color_id": 2,
"first_contact_date": "2025-10-15T00:00:00.000-07:00",
"diagnosis_code": "F11.40",
"created_by": "Shane Carroll, Product Manager",
"updated_by": "Shane Carroll, Product Manager",
"mr_created_at": "2025-10-15T11:01:32.558-07:00",
"closed": false,
"closed_by": null,
"closed_at": null,

"patient_master_id": 14794,
"off_premise": false,
"first_contact_name": "Sam Smith",
"first_contact_relationship": "Parent",
"first_contact_information": "1234123414",
"first_contact_rep_on_call": "Shane Carroll, Product Manager",
"image_processing": null,
"patient_id_image_processing": null,
"pre_admission_status_id": 80,
"pre_admission_status_short_code": null,
"next_review_date": null,
"case_manager_user_id": null,
"sobriety_date": "2025-10-15",
"location_id": 5,
"diag_codes_counter": 6,
"last_coverage_date": null,
"referrer_name": "ABC Detox",
"referrer_id": 2377,
"discharge_to_id": null,
"discharge_to_name": "",
"referrer_person_id": null,
"referrer_contact_required": false,
"allergies_count": 1,
"insurances_count": 2,
"patient_contacts_count": 2,
"payment_method_category": "2",
"discharge_type": null,
"discharge_type_short": null,
"guardian_signature_required": false,
"height_unit": "in",
"weight_unit": "lbs",
"mr_locked": true,
"gender_identity": "Male",
"gender_identity_short": "gender_ident_birth",
"gender_short": "gender_male",
"preferred_name": "Jimbo",
"kis_share_document_id": null,
"preview": false,
"patient_diets_count": 1,
"kipu_messenger_id": null,
"kipu_messenger_status": null,
"anticipated_discharge_date": "2025-10-31T00:00:00.000-07:00",
"restrict_all_users": false,
"record_source": {},
"location_date": "2025-10-15T10:59:00.000-07:00",
"bed_id": 240,
"unreviewed_orders": 74,
"pharmacy_name": null,
"pharmacy_address_street1": null,
"pharmacy_address_street2": null,
"pharmacy_address_city": null,
"pharmacy_address_state": null,

"pharmacy_address_zip": null,
"pharmacy_company_phone": null,
"pharmacy_company_fax": null,
"erx_preferred_pharmacy": false,
"preferred_contact": "phone",
"dose_spot_patient_id": null,
"app_events_emitted_at": null,
"dose_spot_pharmacy_id": null,
"patient_color_date": "2025-10-15T11:00:00.000-07:00",
"billing_transmission_dx_code": null,
"maiden_name": "",
"number": null,
"state_id": "112312",
"cid": "123123",
"ssn_last_4": "3123",
"date_of_birth": "2000-10-25",
"billing_transmission_dx_code_updated_at": null,
"billing_transmission_dx_code_updated_by": null,
"date_of_death": null,
"cause_of_death": "",
"pharmacy_specialties": null,
"building_id": 4,
"building_name": "Ranch East",
"pronouns": "He/him/his/his/himself",
"preferred_language": "English, Old (ca.450-1100)",
"deleted_at": null,
"pharmacy_ncpdp_id": null,
"show_inactive_insurances": true,
"name": "Shane James Export DBH2025-24",
"type": "Patient",
"showUrl": "/calendar/16096/patient",
"extraFields": {
"MR#": "DBH2025-24",
"Diag Code": "F11.40",
"Loc": ""
}
}

**patient.employer**
Not provided

**patient.bed**
East 4-D

**patient.bmi**
Not provided

**patient.level_of_care_clinical**
Not provided

**patient.brought_in_medication**
Not provided

**patient.diagnosis_code**
F11.40

**patient.diagnosis_code_current**
Not provided

**patient.ciwa_ar_current**
Not provided

**patient.diagnosis_code_current**
Not provided

**patient.discharge_datetime**
Not provided

**patient.ethnicity**
Cuban

**patient.locker**
123

**patient.marital_status**
Divorced

**patient.occupation**
Product Manager

**progress_note**
Not provided

**patient.orthostatic_vitals**
Not provided

**patient.orthostatic_vital_signs_current**
Not provided

**patient.vital_signs**
{
"id": 5456,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:55:15.101-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": null,
"created_at": "2025-10-16T08:55:15.392-07:00",
"updated_at": "2025-10-16T08:55:15.392-07:00",
"o2_saturation": null,
"patient_observation_id": null,

"deleted": false,
"record_source": null,
"deleted_by": null,
"deleted_at": null,
"comments": null
}, {
"id": 5455,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:54:50.839-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": null,
"created_at": "2025-10-16T08:54:52.719-07:00",
"updated_at": "2025-10-16T08:54:52.719-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": null,
"deleted_by": null,
"deleted_at": null,
"comments": null
}, {
"id": 5454,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:54:00.000-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": "Shane Carroll, Product Manager ",
"created_at": "2025-10-16T08:54:29.947-07:00",
"updated_at": "2025-10-16T09:12:13.310-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientEvaluationItem",
"deleted_by": null,
"deleted_at": null,
"comments": ""
}, {
"id": 5453,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:45:00.000-07:00",
"blood_pressure_systolic": 110,
"blood_pressure_diastolic": 80,
"temperature": "94.0",
"pulse": 188,
"respirations": 10,

"user_name": "Shane Carroll, Product Manager",
"created_at": "2025-10-16T08:45:49.604-07:00",
"updated_at": "2025-10-16T08:45:49.604-07:00",
"o2_saturation": 80,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null,
"comments": ""
}, {
"id": 5452,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T07:26:00.000-07:00",
"blood_pressure_systolic": 120,
"blood_pressure_diastolic": 80,
"temperature": "98.0",
"pulse": 100,
"respirations": 14,
"user_name": "Shane Carroll, Product Manager",
"created_at": "2025-10-16T07:26:47.433-07:00",
"updated_at": "2025-10-16T07:26:47.433-07:00",
"o2_saturation": 99,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null,
"comments": ""
}

**patient.vital_signs_current**
Not provided

**text**
Not provided

**string**

**string**

**patient.discharge_medications**
Not provided

**patient.discharge_medications**
Not provided

**patient.electronic_devices**
None

# Shambhvee_Evaluation C - import

**Evaluation Name:**
Shambhvee_Evaluation C - import

**Date:**
10/16/2025, 11:54:50 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**time**
10/16/2025, 11:54:50 AM

**Care team**
NAR:: field_type: care_team.Primary_Therapist

# standard_shambhvee_note

**Evaluation Name:**
standard_shambhvee_note

**Date:**
10/16/2025, 11:54:53 AM

**Status:**
status_started

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**text**
Not provided

# Test Chartcheck

**Evaluation Name:**
Test Chartcheck

**Date:**
10/16/2025, 11:54:53 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**text**
Not provided

# test evaluation drop down

**Evaluation Name:**
test evaluation drop down

**Date:**
10/16/2025, 11:54:53 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**dropdown 1**
NAR:: field_type: evaluation_name_drop_down

**dropdown 2**
NAR:: field_type: evaluation_name_drop_down

# third

**Evaluation Name:**
third

**Date:**
10/16/2025, 11:54:54 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:54 AM

**text**
Not provided

## workflow 1

**Evaluation Name:**
workflow 1

**Date:**
10/16/2025, 11:54:54 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

### Evaluation Items

**evaluation_start_and_end_time**
10/16/2025, 11:54:54 AM

**text**
Not provided

# 1038 - Bio-Psychosocial - Kyra

**Evaluation Name:**
1038 - Bio-Psychosocial - Kyra

**Date:**
10/16/2025, 11:54:59 AM

**Status:**
no_signature_requirement

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
265

**Evaluation Items**

**evaluation_start_and_end_time**
10/16/2025, 11:54:59 AM

**Patient Location:**

**Current Diagnosis:**
Not provided

**Precipitating Event / Reason for Care:**
Not provided

**Dimension 1: Intoxication, Withdrawal, and Addiction Medications**

**Do you currently have any withdrawal symptoms:**
None

**P.A.W.S.**
None

**Any symptoms selected above:**
NAR:: field_type: conditional_question

**Are the symptoms due to a medical condition or some other problem?**
Not provided

**Have any of these symptoms kept you from doing social, family, job or other activities?**
Not provided

**Have you used alcohol and/or other drugs to stop or avoid having these symptoms?**
Not provided

**Cravings scale 0-10:**

**Substance Use Background:**

**matrix**
None

**History of overdose?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**History of complicated withdrawal (withdrawal seizures, delirium tremens along with psychological symptoms)?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Additional Comments:**
Not provided

**Dimension 1: Intoxication, Withdrawal, and Addiction Medications**

**Dimension 2: Biomedical Conditions**

**Medical conditions:**
Not provided

**Medical Family history:**
Not provided

**Do you have any known allergies?**
{
"id": 6629,
"patient_id": 16096,
"allergen": "Pollen",
"reaction": "Hives",
"treatment": "",
"created_at": "2025-10-15T12:28:36.309-07:00",
"updated_at": "2025-10-15T12:28:55.820-07:00",
"created_by": "Shane Carroll, Product Manager",
"updated_by": "Shane Carroll, Product Manager",
"allergy_type": "other",
"deleted": false,
"deleted_at": null,
"deleted_by": null,
"onset": null,
"reaction_type": "Allergy",
"status_type": "Active",
"source": "",
"dose_spot_code": "",
"dose_spot_allergy_id": null,
"show_on_wristband": false,
"dose_spot_code_type": "",
"allergen_id": null,
"allergy_severity_id": null,
"rcopia_id": null

}

**Does your substance use affect your medical conditions in any way?**
NAR:: field_type: conditional_question

**If yes, explain:**
Not provided

**Most recent 1095 - Current Medications for information regarding current medications.**
None

**Hospitalization and Surgical History:**
Not provided

**Pain Assessment Scale:**

**Do you have pain now?**
NAR:: field_type: conditional_question

**Where?:**
Not provided

**Rate the pain to relation to what represents the amount of pain you are experiencing:**

**Is this pain related to withdrawal?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**How long have you been in pain?**
Not provided

**What makes the pain better or worse?**
Not provided

**What medications or coping skills do you use to relieve or reduce your pain?**
Not provided

**Where are you getting these medications?**
None

**Are you under a doctor's care for this pain?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Do you have trouble sleeping?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Assistive Technology**

**Do you have any disabilities, hearing or vision impairments, or difficulty reading that requires the use of assistive technology, aids, or supports?**
NAR:: field_type: conditional_question

**What Assistive Technology do you require?**
Not provided

**Assistive Technology will be provided through:**
Not provided

**Do you need assistance finding provider for Assistive Technology?**

**Do you have an Advance Directives?**

**Would you like information on Advance Directives?**

**Dimension 2: Biomedical Conditions**

**Dimension 3: Psychiatric and Cognitive Conditions**

**As a child, did you experience any serious physical illness, injuries or mental illnesses causing trauma?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Psychiatric History:**
Not provided

**Do you have a persistent disability?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Alternative Therapies:**
None

**Family Behavioral History**
Not provided

**Have you ever been the victim of or witnessed abuse / trauma?**
NAR:: field_type: conditional_question

**If yes:**
None

**When and by whom:**
Not provided

**Did you receive treatment?**
NAR:: field_type: conditional_question

**If yes, explain:**
Not provided

**Was the treatment helpful?**
NAR:: field_type: conditional_question

**Please explain:**
Not provided

**Additional Comments:**
Not provided

**Have you ever been the perpetrator of abuse / trauma?**
NAR:: field_type: conditional_question

**If yes:**
None

**When and to whom?**
Not provided

**Did you receive treatment?**
Not provided

**Additional Comments:**
Not provided

**Do you have a history, or engage in current, self harm?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**In the last year have you felt like hurting or killing yourself? (suicidal ideation)**
NAR:: field_type: conditional_question

**Identify the patient's plan and/or intent to harm themselves, if any**
Not provided

**In the last year have you felt like hurting or killing others? (homicidal ideation)**
NAR:: field_type: conditional_question

**Identify the patient's plan and/or intent to harm others, if any**
Not provided

**In the last year, have you experienced hallucinations or difficulty telling what is real from that which is not? (auditory, visual, olfactory, tactile)?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**In the last year, have you had trouble remembering, concentrating or following simple instructions?**

**Additional Comments:**
Not provided

**COLUMBIA - Suicide Severity Rating Scale**

**1) In the past month, have you wished you were dead or wished you could go to sleep and not wake up?**

**2) In the past month, have you actually had any thoughts of killing yourself?**
NAR:: field_type: conditional_question

**3) In the past month, have you been thinking about how you might kill yourself?**

**4) In the past month, have you had these thoughts and had some intention of acting on them?**

**5) In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?**

**6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?**

**formatted_text**
Scoring: If "Yes" to question 4, 5, and/or 6, suicide risk level is high. If yes to question 1, 2, 3, or 4 but NOT 5 or 6, suicide risk level is medium. if "No to all questions, suicide risk level is low.

**Protective Factors:**
Not provided

**Risk Factors:**
Not provided

**Risk**

**check_box**
None

**Referred To:**

**Additional:**
Not provided

**Does this patient need a Safety Plan Created?: (selecting yes will generate evaluation in the chart)**
NAR:: field_type: create_evaluation

**Military Service History:**

**Have you ever served as Active Duty:**
NAR:: field_type: conditional_question

**What was your Military Occupational Specialty (MOS):**
Not provided

**Combat Deployment:**
NAR:: field_type: conditional_question

**Did you experience traumatic events while deployed?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Were you Stop Lost:**
NAR:: field_type: conditional_question

**Were you disenchanted with Military upon Stop Loss:**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Did you receive Mental Health Care Downrange:**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**How did you exit the military:**
None

**Have you enrolled in the VA:**

**Mental Status Examination**

**While prompts are provided below, the assessor should make sure to describe his/her observations and impressions of the person for each grouping below.**

**Orientation (capacity to identify and recall one's identity and place in time and space, ask directed questions.)**

**Orientation:**
None

**General Appearance (include general observations about the person's appearance and expression)**

**Dress:**

None

**Grooming:**
None

**Facial Expression:**
None

**Mood/Affect (Mood: sustained emotional state; emotional tone the client subjectively feels i.e what the client says / Affect: outward expression of person's current feeling state, how they appear to you i.e facial expressions**

**Mood:**
None

**Affect:**
None

**Self-Concept (How patient perceives his / her behavior, abilities, and unique characteristics.)**

**Self-Concept:**
None

**Speech (comment on tone, volume, and quantity)**

**Speech:**
None

**Memory (could explain recent and past events in their history; recalls three words immediately after rehersal than five minutes later; recalls your name after 30 minutes)**

**Immediate:**
None

**Recent:**
None

**Remote:**
None

**Thought Process (the movement of thought, the dynamics of how one thought connects to the next; observe speech, some behavior; may need a few targeted questions)**

**Thought Process:**
None

**Thought Content (A description of the topics one is thinking aloud)**

**Thought Content:**
None

**Judgement and Insight (Judgement: ability to make wise decisions, especially in everyday activities and social matters; insight; awareness of problems, what they are, and their implications)**

**Judgement:**
None

**Insight:**
None

**Comments:**
Not provided

**Dimension 3: Psychiatric and Cognitive Conditions**

**Dimension 4: Substance Use-Related Risks**

**Do you think you have a problem with alcohol or other substance use disorder and/or mental/emotional disorders?**

**Have you tried to hide your substance use disorder?**

**Has anyone ever expressed concern about your substance use disorder?**

**Has your substance use disorder caused you to feel depressed, nervous, suspicious, decreased sexual desire, diminished your interest in normal activities or cause other psychological problems?**

**Has your substance use disorder negatively affected your health?**

**Have you continued to use despite the negative consequences (at work, school, or home) of your use?**

**Have you continued to use despite placing yourself and other in dangerous or unsafe situations?**

**Has your use caused you legal problems or inability to comply with legal requirements?**

**Has your substance use disorder affected you socially (fights, conflicts in relationships, etc.)?**

**Do you need more of your substance of choice to get the same high?**

**Do you spend a great deal of time in activities to obtain alcohol and/or other drugs and/or feeling its effects?**

**Has your substance use disorder caused you to give up or not participate in social, occupational or recreational activities that you once enjoyed?**

**Have you continued to use after knowing it caused or contributed to physical or psychological problems?**

**Have you used larger amounts of your substance of choice than you intended?**

**What type of risky behavior is associated with your current substance use behavior? (needle sharing, use of substances without knowing what the substance is, driving while under the influence, risky sexual behavior, etc.)**

Not provided

**STI screening:**
None

**Aware of your HIV Status?**

**Have you ever had a positive TB skin test or TB blood test?**

**Have you ever had a severe reaction to a TB skin test?**

**Have you ever taken medication for Tuberculosis?**

**Have you had the BCG vaccine?**

**Have you been in contact with someone who has TB disease?**

**Identified Internal Triggers:**
None

**Identified External Triggers:**
None

**Identified Coping Skill:**
None

**Identified Social and Leisure Activities:**
Not provided

**Internal Motivators:**
None

**External Motivators:**
None

**Indicate the Stage of Change:**

**Alcohol use:**

**Drug use:**

**Dimension 4: Substance Use-Related Risks**

**Explain:**
Not provided

**Dimension 5: Recovery Environment Interactions**

**Have you ever been treated for a substance use disorder problem?**
NAR:: field_type: conditional_question

**matrix**
None

**Comments:**
Not provided

**Have you had any periods of recovery due to a substance use disorder?**
NAR:: field_type: conditional_question

**1. How was that recovery/maintenance achieved? Please explain:**
Not provided

**What triggers are associated with your substance use? Please explain.**
Not provided

**What factors/triggers contributed to a return to use in the past?**
Not provided

**Are you participating or have you participated in any support groups (AA, NA, church, other)**
NAR:: field_type: conditional_question

**If yes, how often?**
Not provided

**Do you have a sponsor?**

**In the past year, have you tried to reduce the effect of your alcohol and/or other drugs problems?**
NAR:: field_type: conditional_question

**If yes, explain:**
Not provided

**Have you had any periods without mental/emotional problems?**
NAR:: field_type: conditional_question

**1. How was maintenance achieved?**
Not provided

**2. What causes the symptoms to get worse?**
Not provided

**Risk of return or continued problematic use:**

**Clinical Reason for continued or return to use:**
None

**Barriers Which May Impact Recovery Outcomes Since Last Review: (or intake if this is the first completion)**
None

**Additional comments:**

Not provided

**Dimension 5: Recovery Environment Interactions**

**Dimension 6: Person-Centered Considerations**

**Living arrangement:**
None

**Living arrangement details:**
Not provided

**Number in household?**

**Is your current living environment supportive to your goals?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Do you have access to adequate food and nutrition?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Current Employment Status**
None

**Employment arrangement details:**
Not provided

**Employment History**
None

**Education**

**Are you currently in school, enrolled in GED program, or vocational program?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Highest level of education:**

**Can you read and write at a level that satisfies you:**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**Legal**

**Detailed Legal Status**
None

**Current Charges:**

**Arrested in 30 days prior to admission:**

**Explanation of the above to include outcome:**
Not provided

**Family**

**Do you have dependent children?**
NAR:: field_type: conditional_question

**1. If yes, how many and their ages?**
Not provided

**2. Who has custody of these children?**
Not provided

**3. Is there childcare available for these children? (if yes, explain)**
Not provided

**4. Do any of your children have any behavior or developmental problems?**
Not provided

**5. Are you required to pay child support?**
NAR:: field_type: conditional_question

**If yes, are you current in your child support?**

**6. Do you feel you have adequate parenting skills?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**7. Would you be interested in receiving more parenting skills?**
NAR:: field_type: conditional_question

**Explain:**
Not provided

**8. Are you the primary care giver for anyone other than your children? (parents, siblings, other adults, etc.)**
Not provided

**Quality of interaction with family and/or support system:**

**Level of satisfaction with support system:**

**matrix**
None

**Explain:**
Not provided

**Do you have reliable transportation?**
NAR:: field_type: conditional_question

**Explain how lack of transportation affects access to treatment or other services:**
Not provided

**Does the patient have a valid drivers license or ID issued by the state they are receiving services in?**
NAR:: field_type: conditional_question

**Explain how lack of valid ID affects access to treatment or other services, plan to obtain valid ID**
NAR:: field_type: conditional_question

**Sexual Orientation/Gender Identity**

**What sex were you assigned at birth?**

**How do you identify?:**
None

**Which of the following best describes you?:**

**Are there any additional identity related topics you would like to share that are relevant to your care?:**
NAR:: field_type: conditional_question

**What would you like to share?:**
Not provided

**Religious/Spiritual/Cultural**

**Please describe your religious preferences, practices, and engagement, if any?**
Not provided

**Please describe your spiritual preferences, practices, and engagement, if any?**
Not provided

**How do you want your religious or spiritual practices incorporated into your treatment?**
Not provided

**How does your culture, spiritual, or religious community view substance use?**
Not provided

**Strengths:**
None

**Needs:**
None

**Abilities:**
None

**Preferences:**
None

**What are your goals for treatment? (Reduce use, stop use, learn more about use, etc.)**
Not provided

**What is the patient's ability to access and engage in the recommended level of care considering the patient's preferences?**
Not provided

**What services are needed to support and build readiness and motivation for change? (Care coordination needs check all that apply)**
None

**Are there any unmet needs that may impact the patient's ability to achieve their goals?**
Not provided

**Dimension 6: Person Centered Considerations:**

LEVEL OF CARE PLACEMENT SUMMARY

**Assessed:**
None

**Placed:**
None

**Reason for Difference:**
None

**The following problems were identified:**
None

**Release of information:**
None

**Orientation Completed:**
None

**Interpretive Summary**

**Interpretive Summary is a written clinical formulation designed to integrate and interpret from a broader perspective all history and assessment information collected. It identifies needs and addresses how they are considered when developing the person-centered plan. It identifies any co-occurring disabilities, comorbidities and/or disorders. Be sure to include the physician diagnosis in order of severity from the**

History and Physical Form 1030.

Summary:
Not provided

# CMHS discharge Summary - Active - import - import

**Evaluation Name:**
CMHS discharge Summary - Active - import - import

**Complete:**
No

**Date:**
10/16/2025, 11:54:54 AM

**Tab Name:**
Evaluations

**Status:**
no_signature_requirement

**Items Count:**
24

**Evaluation Items**

**Today's Date:**
10/16/2025, 11:54:54 AM

**Date of Discharge:**
Not provided

**Discharge Type:**
Not provided

**Patient Birthday**
Not provided

**Did patient relapse while in treatment?**

**Level of Care at Discharge:**

**Length of Stay:**

**Medications at the Time of Discharge:**
Not provided

**Reason for Admission:**
Not provided

**Emergency Contact Name**

**Emergency Contact Name Phone Number**

**Emergency Contact email**

**Insurance information**

**Ethnic/Cultural Considerations**

**Ethnicity:**

**Physician**

**Patient Address**

**Language**

**Patient identifies as:**

**Clinical Summary of Client's Response to Treatment:(strengths/weaknesses, specific needs and concerns upon discharge)**
Not provided

**Unresolved issues that could affect continuing recovery:**
Not provided

**Legal concerns at time of discharge?**
Not provided

**Condition at Discharge:**
Not provided

**Progress on Treatment Plan Goals**
Not provided

# Bio-psychosocial Assessment - import

**Evaluation Name:**
Bio-psychosocial Assessment - import

**Date:**
10/16/2025, 11:55:09 AM

**Status:**
no_signature_requirement

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
201

**Evaluation Items**

**Date/Time:**
10/16/2025, 11:55:09 AM

**Sobriety Date:**
Not provided

**I. SOCIAL AREA**

**Is there another language outside of English that you need your records and/or provider to be able to speak?**
Not provided

**A. Family of Origin**

**1. Where were you raised and by whom?**
Not provided

**2. Do you have any siblings?**
None

**3. How were the relationships between family members in the immediate family/in the household?**
Not provided

**4. Who do you feel closest to in the family and why?**
Not provided

**5. What would you do feel about your childhood history that is relevant to your substance use or mental health history?**
Not provided

**6. Is there any history of the following:**

**Mother:**
None

**Father:**
None

**Step-Parent:**
None

**Siblings:**
None

**Other:**
None

**If YES to any of the above, elaborate:**
Not provided

**B. Family of Choice**

**1. Are you involved in a significant relationship?**
Not provided

**If YES, are you satisfied with relationship with partner?**
Not provided

**2. Marriage History:**
None

**3. Do you have any children?**
None

**4. Are you satisfied with your relationship with your children?**

**5. Is there any history of the following:**

**Partner:**
None

**Past Partner:**
None

**Children:**
None

**If YES to any of the above, elaborate:**
Not provided

**C. Cultural Influences or Preferences**

**1. Were you raised in any specific culture?**
Not provided

**2. Do you identify with any specific cultural group?**
Not provided

**3. Do you currently practice any specific cultural rituals?**

Not provided

D. Spirituality/Religious Assessment

1. Is religion or spirituality important in your life?
Not provided

2. Do you use prayer/meditation?
Not provided

3. How does your faith help you cope with problems in your life?
Not provided

II. LEGAL HISTORY

1. Is Client currently involved in the Criminal Justice System?
Not provided

2. Have you ever been incarcerated?

If YES, list incarceration history, most recent first:
None

3. Do you currently owe any restitution?
Not provided

4. How much will your legal situation influence your progress in treatment:
Not provided

5. What is the urgency of your legal situation?
Not provided

6. Is the legal situation related to your current issues with substance use or mental illness?
Not provided

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?
Not provided

3. Do you have any future educational goals?
Not provided

B. Employment History

1. Has Client ever been employed?

If YES, list employment history (most recent first):
None

2. Do you need/want any specific vocational training?
Not provided

3. Have you ever received any vocational training?
Not provided

C. Military Service

1. Have you ever served in the Military?

If YES:
None

Additional information / comments concerning Educational / Vocational Issues:
Not provided

IV. SEXUAL / ABUSE / TRAUMA HISTORY

Describe your present sexual orientation:

Check all that apply:For all checked, describe below.

check_box
None

If YES, was it alcohol/drug related?

Explain any checked items above:
Not provided

Are you currently in or have you ever been involved in an abusive relationship?
Not provided

TRAUMA ASSESSMENT:Have you ever experienced any of the following types of trauma?

Significant death of a family member or friend:

Witnessing an Accident:

Community Violence:

Domestic Violence:

Childhood Trauma:

Natural Disaster:

Family Violence:

**Neglect:**

**Any type of physical, sexual or emotional abuse:**

**School Violence:**

**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:**
Not provided

**Do you feel that this trauma may interfere with treatment and/or has led to past relapses?**
Not provided

**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:**
None

## V. LEISURE/RECREATIONAL ACTIVITIES

**List any hobbies, recreational interests, sports, games or other leisure activities you enjoy:**
Not provided

**What effect has your substance use had on your leisure time?**
Not provided

**check_box**
None

## VI. CURRENT/USUAL SOCIAL ENVIRONMENT

**Family circumstances, including but not limited to bereavement, divorce, or incarceration of a family member**
None

## VII. CURRENT FINANCIAL STATUS

**Current Financial Status & How did you pay for Drug/Alcohol Addiction?**
Not provided

**1. Are you currently having any financial issues?**

**2. How would you describe your current financial situation?**

**3. If paying for drugs/alcohol has ever been an issue, is there anything you would like to share with the treatment team about how you obtain drugs/alcohol?**
Not provided

## VIII. CONSEQUENCES OF ADDICTION

**1. Describe client's consequences of addiction:**

## IV. SUBSTANCE USE HISTORY & ASSESSMENT

**Substance History:**
None

**Other Drugs Used:**
None

**Consequences of substance use**
Not provided

**Assessment for Other Addictive Disorders**

**History of Other Addictive Behaviors:**

**Eating Disorders?**
None

**Have you ever received treatment for an Eating Disorder?**

**Is Eating Disorder still an issue for you?**

**Do you have a history of Gambling?**
Not provided

**Do you feel that gambling is an issue for you?**

**Are there other addictive behaviors (work, nicotine, sex, caffeine, shopping, and/or exercising) that the you have a problem with?**
Not provided

**Are there any other addictive disorders that will need to be addressed in treatment?**
Not provided

**List Drugs of Choice:**
Not provided

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

**Treatment History**

**Number of Times:**

**Previous Treatment:**
None

**Relapses: Is there anything that you would like to discuss around relapses that you've experienced? What would you like to share about what a relapse looks like for you?**
Not provided

**Abstinence/Recovery: Is there anything relevant you would like share about your abstinence/recovery**

**history, including community and/or recovery supports.**
Not provided

**What treatment is working for this client? What worked/didn't work; What was helpful; How did you respond?**
Not provided

**What precipitating events lead to relapse (i.e. triggers)?**
Not provided

## X. TREATMENT ACCEPTANCE / RESISTANCE DIMENSION

**1. Describe your external motivation for Treatment?**
Not provided

**2. Describe your internal motivation for Treatment?**
Not provided

**3. Relapse/Continued Use Potential**

**Client's Strengths:**
None

**Client's Weaknesses:**
None

**Barriers to Treatment:**
None

**Describe your needs, strengths, preferences, and goals:**
Not provided

**4. On a scale from 1 – 10, 10 being VERY READY, what is your readiness for change?**

## XI. RECOVERY ENVIRONMENT

**1. Do you have an existing positive support system?**
Not provided

**2. Is your current living environment conducive to progress in therapy?**
Not provided

**3. Are you currently engaged in any substance-free leisure activities or hobbies?**
Not provided

**4. What strengths do you have that will assist you in regards to recovery?**
Not provided

**5. Additional information / comments concerning recovery environment issues:**
Not provided

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?
Not provided

2. Has any family member / significant other attempted to address/intervene in Client's behavior and/or usage?

Why or Why Not?
Not provided

3. Has family member / significant other noticed any changes in Client's behavior?
Not provided

4. Have there been any traumatic events in the family or specific to the Client?
Not provided

5. Is family member / significant other willing to participate in Client's treatment?
Not provided

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.
Not provided

XII. ASSESSMENT OF MENTAL STATUS DURING INTERVIEW

APPEARANCE:
None

AFFECT:
None

MOOD:
None

BEHAVIOR:
None

ORIENTATION:
None

INSIGHT:
None

JUDGMENT:
None

LEVELS OF IMPAIRMENT / SEVERITY RATINGS

RATE CLIENT'S LEVEL OF IMPAIRMENT & SEVERITY:RATING/SEVERITY SCALE:0 – Not at all1 – Slightly2

– Moderately3 – Considerably4 – Extremely

PROBLEMS:
Not provided

MEDICAL:
Not provided

EMPLOYMENT:
Not provided

PEER SUPPORT:
Not provided

DRUG/ALCOHOL USAGE:
Not provided

LEGAL:
Not provided

FAMILY/SOCIAL:
Not provided

PSYCHIATRIC - MENTAL HEALTH:
Not provided

TOTAL SCORE:
NAR:: field_type: points_total

OVERALL LEVEL OF IMPAIRMENT & SEVERITY 0Not at all impaired 1-7Slightly impaired 8-15Moderately impaired 16-23Considerably impaired 24 & OVERExtremely impaired

HOW WOULD YOU DESCRIBE YOUR ABILITY TO SELF CARE?
Not provided

RATIONALE FOR TREATMENT AT THIS LEVEL OF CARE:
Not provided

REASON FOR TREATMENT AT THIS TIME:
Not provided

Short Term Goals:
Not provided

Long Term Goals:
Not provided

INTEGRATED DIAGNOSTIC SUMMARY/CLINICAL IMPRESSION:
Not provided

Diagnosis:

F11.40

**List Problems Identified in Bio-Psychosocial:**
None

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

**golden_thread_tag**
None

**Will your family be involved in the treatment process?**

**If yes: Family's perception of needs, preferences, goals for their Tx episode:**
Not provided

**If no: Why not/Reason:**
Not provided



**Sober Date:**
Not provided

**List Problems Identified in Bio-Psychosocial:**
List Problems Identified in Bio-Psychosocial:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**Date**
Not provided

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

**1. Little interest or pleasure in doing things**
Not provided

**2. Feeling down, depressed, or hopeless**
Not provided

**3. Trouble falling or staying asleep, or sleeping too much**
Not provided

**4. Feeling tired or having little energy**
Not provided

**5. Poor appetite or overeating**
Not provided

**6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down**
Not provided

**7. Trouble concentrating on things, such as reading the newspaper or watching television**
Not provided

**8. Moving or speaking slowly, or being fidgety/restless?**
Not provided

**9. Thoughts of being better off dead or hurting yourself?**
Not provided

**Total Score**
NAR:: field_type: points_total

**Treatment:**
Not provided

**Discharge:**
Not provided

GENERALIZED ANXIETY DISORDER (GAD-7) SCALE

**Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle the number to indicate your answer)**
Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle the number to indicate your answer)

**1. Feeling nervous, anxious, or on edge**
Not provided

**2. Not being able to stop or control worrying**
Not provided

**3. Worrying too much about different things**
Not provided

**4. Trouble relaxing**
Not provided

**5. Being so restless that it's hard to sit still**
Not provided

**5. Being so restless that it's hard to sit still**
Not provided

**6. Becoming easily annoyed or irritable**
Not provided

**7. Feeling afraid as if something awful might happen**
Not provided

**Total Score:**
NAR:: field_type: points_total

**Treatment:**
Not provided

**Discharge:**
Not provided

# Recovery AI Test

**Evaluation Name:**
Recovery AI Test

**Date:**
10/16/2025, 11:55:06 AM

**Status:**
no_signature_requirement

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

## Evaluation Items

**Presenting Substance Abuse History**
Not provided

**Relevant Social History**
Not provided

**Family History**
Not provided

**Psychiatric History**
Not provided

# EMR-28980

**Evaluation Name:**
EMR-28980

**Date:**
10/16/2025, 11:55:14 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
2

## Evaluation Items

**Form**
Not provided

**Editing**
None

# test_90%60

**Evaluation Name:**
test_90%60

**Date:**
10/16/2025, 11:55:13 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

**Evaluation Items**

**Test**

# AI_Form_Abhinav

**Evaluation Name:**
AI_Form_Abhinav

**Date:**
10/16/2025, 11:55:14 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

### Evaluation Items

**Disease**
Not provided

**Medications**
Not provided

**Symptoms**
Not provided

**Progress Plan**
Not provided

# COWC/CIWA/Vitals/Height & Weight

**Evaluation Name:**
COWC/CIWA/Vitals/Height & Weight

**Date:**
10/16/2025, 11:55:15 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
5

### Evaluation Items

**conditional_question**
NAR:: field_type: conditional_question

**patient.ciwa_b**
Not provided

**patient.cows**
{
"id": 2093,
"patient_id": 16096,
"pulse_rate": null,
"sweating": null,
"restlessness": null,
"pupil_size": null,
"bone_joint_ache": null,
"runny_nose": null,
"gi_upset": null,
"tremor": null,
"yawning": null,
"anxiety_irritability": null,
"gooseflesh_skin": null,
"username": null,
"interval": null,
"created_at": "2025-10-15T12:31:11.465-07:00",
"updated_at": "2025-10-15T12:31:11.465-07:00",
"status": "empty",
"record_source": null,
"deleted_by": null,
"deleted_at": null
}, {
"id": 2097,
"patient_id": 16096,
"pulse_rate": null,
"sweating": null,
"restlessness": null,
"pupil_size": null,
"bone_joint_ache": null,
"runny_nose": null,

"gi_upset": null,
"tremor": null,
"yawning": null,
"anxiety_irritability": null,
"gooseflesh_skin": null,
"username": null,
"interval": null,
"created_at": "2025-10-16T08:55:15.375-07:00",
"updated_at": "2025-10-16T08:55:15.375-07:00",
"status": "empty",
"record_source": null,
"deleted_by": null,
"deleted_at": null
}, {
"id": 2096,
"patient_id": 16096,
"pulse_rate": null,
"sweating": null,
"restlessness": null,
"pupil_size": null,
"bone_joint_ache": null,
"runny_nose": null,
"gi_upset": null,
"tremor": null,
"yawning": null,
"anxiety_irritability": null,
"gooseflesh_skin": null,
"username": "Shane Carroll, Product Manager",
"interval": "2025-10-16T09:14:00.000-07:00",
"created_at": "2025-10-16T08:54:29.912-07:00",
"updated_at": "2025-10-16T09:15:39.041-07:00",
"status": "empty",
"record_source": "PatientEvaluationItem",
"deleted_by": null,
"deleted_at": null
}, {
"id": 2095,
"patient_id": 16096,
"pulse_rate": 1,
"sweating": 2,
"restlessness": 1,
"pupil_size": 2,
"bone_joint_ache": 0,
"runny_nose": 0,
"gi_upset": 0,
"tremor": 1,
"yawning": 0,
"anxiety_irritability": 1,
"gooseflesh_skin": 0,
"username": "Shane Carroll, Product Manager",
"interval": "2025-10-16T08:46:00.000-07:00",
"created_at": "2025-10-16T08:46:57.643-07:00",

"updated_at": "2025-10-16T08:46:57.643-07:00",
"status": "active",
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null
}, {
"id": 2094,
"patient_id": 16096,
"pulse_rate": 1,
"sweating": 1,
"restlessness": 1,
"pupil_size": 1,
"bone_joint_ache": 1,
"runny_nose": 1,
"gi_upset": 1,
"tremor": 1,
"yawning": 1,
"anxiety_irritability": 1,
"gooseflesh_skin": 3,
"username": "Shane Carroll, Product Manager",
"interval": "2025-10-16T07:27:00.000-07:00",
"created_at": "2025-10-16T07:27:42.222-07:00",
"updated_at": "2025-10-16T07:27:42.222-07:00",
"status": "active",
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null
}

**patient.vital_signs**

{
"id": 5456,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:55:15.101-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": null,
"created_at": "2025-10-16T08:55:15.392-07:00",
"updated_at": "2025-10-16T08:55:15.392-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": null,
"deleted_by": null,
"deleted_at": null,
"comments": null
}, {
"id": 5455,
"patient_id": 16096,

"interval_timestamp": "2025-10-16T08:54:50.839-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": null,
"created_at": "2025-10-16T08:54:52.719-07:00",
"updated_at": "2025-10-16T08:54:52.719-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": null,
"deleted_by": null,
"deleted_at": null,
"comments": null
}, {
"id": 5454,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:54:00.000-07:00",
"blood_pressure_systolic": null,
"blood_pressure_diastolic": null,
"temperature": null,
"pulse": null,
"respirations": null,
"user_name": "Shane Carroll, Product Manager ",
"created_at": "2025-10-16T08:54:29.947-07:00",
"updated_at": "2025-10-16T09:12:13.310-07:00",
"o2_saturation": null,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientEvaluationItem",
"deleted_by": null,
"deleted_at": null,
"comments": ""
}, {
"id": 5453,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T08:45:00.000-07:00",
"blood_pressure_systolic": 110,
"blood_pressure_diastolic": 80,
"temperature": "94.0",
"pulse": 188,
"respirations": 10,
"user_name": "Shane Carroll, Product Manager",
"created_at": "2025-10-16T08:45:49.604-07:00",
"updated_at": "2025-10-16T08:45:49.604-07:00",
"o2_saturation": 80,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientChart",
"deleted_by": null,

"deleted_at": null,
"comments": ""
}, {
"id": 5452,
"patient_id": 16096,
"interval_timestamp": "2025-10-16T07:26:00.000-07:00",
"blood_pressure_systolic": 120,
"blood_pressure_diastolic": 80,
"temperature": "98.0",
"pulse": 100,
"respirations": 14,
"user_name": "Shane Carroll, Product Manager",
"created_at": "2025-10-16T07:26:47.433-07:00",
"updated_at": "2025-10-16T07:26:47.433-07:00",
"o2_saturation": 99,
"patient_observation_id": null,
"deleted": false,
"record_source": "PatientChart",
"deleted_by": null,
"deleted_at": null,
"comments": ""
}

**patient.height_weight**
Not provided

# Height & Weight Fields with Conditional Question

**Evaluation Name:**
Height & Weight Fields with Conditional Question

**Date:**
10/16/2025, 11:55:15 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
6

### Evaluation Items

**patient.height_weight**
Not provided

**patient.height_weight**
Not provided

**patient.bmi**
Not provided

**Testing H/W for Patient :**
NAR:: field_type: conditional_question

**H/W**
Not provided

**patient.bmi**
Not provided

# Height and Weight Form

**Evaluation Name:**
Height and Weight Form

**Date:**
10/16/2025, 11:55:14 AM

**Status:**
status_empty

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
4

### Evaluation Items

**Date/Time:**
10/16/2025, 11:55:14 AM

**Height & Weight:**
Not provided

**conditional_question**
NAR:: field_type: conditional_question

**Height Weight**
Not provided

# Test Optional field

**Evaluation Name:**
Test Optional field

**Date:**
10/16/2025, 11:55:16 AM

**Status:**
no_signature_requirement

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
1

### Evaluation Items

**Test Optional field**
Not provided

# 1141_eval

**Evaluation Name:**
1141_eval

**Date:**
10/16/2025, 11:54:00 AM

**Status:**
status_complete

**Complete:**
Yes

**Tab Name:**
Evaluations

**Items Count:**
3

### Evaluation Items

**DATE/TIME**
10/16/2025, 11:54:00 AM

**employer name**
Not provided

**patient.electronic_devices**
None

# Manage Diagnosis Code (new) (DRAFT)

**Evaluation Name:**
Manage Diagnosis Code (new) (DRAFT)

**Date:**
10/16/2025, 11:54:00 AM

**Status:**
status_started

**Complete:**
No

**Tab Name:**
Evaluations

**Items Count:**
3

**Evaluation Items**

**Todays Date**
10/16/2025, 11:54:00 AM

**Patient Diagnosis**
F11.40

**Comments**