



## Community Based Intake/Orientation Packet

FORMS	PAGES	✓
Service Recipient Orientation Checklist (copy to client)	1 pg	
Client Consent or Objection to Participate	1 pg	
Emergency Medical Information	1 pg	
Insurance Card (Copy front and back for EHR)	1-2 pg	
Medical Emergency Transport Authorization	1 pg	
Authorization to Transport	1 pg	
Service Appeal Process (copy to client)	1 pg	
Choice of Service Provider	1 pg	
Notice of Privacy Practices (copy to client)	1 pg	
Medical Information Rights (copy to client)	1 pg	
Notice of Client Rights and Responsibilities (copy to client)	2 pgs	
Initial Treatment Plan (ISP)-circle if ISP is written or in LAURIS	1 pg <b>WRITTEN/LAURIS</b>	
Authorization(s) for Release of Information	_____ pgs	
Adult Fall Risk Assessment	1 pg	
CHILD ONLY FORMS		
EPSDT Letter to Parent/Guardian (copy to client)	1 pg	
EPSDT Screening Document & Request for Information (OM note fax confirmation date to PCP)	2 pgs	Date Faxed:
Humpty Dumpty Fall Risk Assessment	1 pg	
IF APPLICABLE		
Telehealth Consent (add non-billable note)	1 pg	
Supervisee in Social Work Acknowledgement Form	1 pg	
Resident in Counseling Acknowledgement Form	1 pg	

Assessor's Name (Printed)



## Service Recipient Orientation – Checklist

- ✓ Service Recipient Orientation Checklist (copy to client)
- ✓ Client Consent or Objection to Participate
- ✓ Insurance Card (Copy front and back for EHR)
- ✓ Medical Emergency Transport Authorization
- ✓ Authorization to Transport
- ✓ Service Appeal Process (copy to client)
- ✓ Choice of Service Provider
- ✓ Notice of Privacy Practices (copy to client)
- ✓ Medical Information Rights (copy to client)
- ✓ Notice of Client Rights and Responsibilities (copy to client)
- ✓ Telehealth Consent (if applicable)
- ✓ EPSDT Letter to Parent/Guardian (copy to client)-Child Only
- ✓ Overview of Service Delivery, and Discharge Process
- ✓ Charges or Fees Due (if applicable)

**The Family Insight Assessor has explained these policies and procedures to me. I have received copies of them. I understand that there are risks if I do not participate in treatment. My symptoms may get worse or Family Insight may have to give my appointment times to another individual. I understand and have completed my Orientation to the Services Program, and I understand I may contact Family Insight staff if I have any questions.**

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Signature of Client

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Date

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Signature of Parent/Guardian

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Date

---

Family Insight Representative

---

Date



## Client Consent or Objection to Participation in the Assessment and Treatment Process

### INFORMED CONSENT

By our signatures below, we agree to participate in the assessment and treatment process.

(Initial here) I/We **consent** to be contacted 90 days after services have ended to complete brief outcome measures & client satisfaction surveys.

(Initial here) I/We **decline** to be contacted 90 days after services have ended to complete brief outcome measures & client satisfaction surveys.

We have been informed that we may revoke our consent at any time. We give this consent freely.

Child/Client Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Family Insight Provider Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_



**\*\*\*CONFIDENTIAL\*\*\***

## Client Emergency Medical Information Form

Name:		DOB:	
Social Security Number:		Email:	
Address:			
Home Phone:			
Work Phone:			

**PERSON TO BE NOTIFIED IN THE EVENT OF AN EMERGENCY:**

Name:	
Address:	
<input type="checkbox"/> Same as Client?	
Alternate Email :	
Home Phone:	
Work Phone:	

**EVACUATION ADDRESS IN THE EVENT OF AN EMERGENCY (Where are you most likely to go?):**

Location Name:	
Person(s) at this location	
Address:	
Home Phone:	
Work Phone:	
Mobile Phone:	

Y   N

Are there pets in the home that would require evacuation & shelter during an emergency?

**If yes, list name, breed & size of animal (RED FLAG)**

Pet's Name	Breed	Size



## Medical Emergency Transport Authorization

Family Insight staff will call local 911 for emergency services on your behalf in case of medical or behavioral health emergency. Family Insight will not incur the cost for transportation by ambulance or other emergency vehicle in case of emergency.

I understand that FI policy does not allow employees to transport a client or family member who is experiencing a medical or behavioral health emergency. If I experience an emergency while the employee is already transporting me, the employee will find a safe place to pull over, call EMS and the emergency contact, and render all possible first aid within their training.

**My signature below gives authorization for Family Insight staff to contact Emergency Medical Services on my behalf and relieves Family Insight from any cost incurred for services rendered by Emergency Medical Service.**

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Signature of Client

---

Date

---

Signature of Parent/Guardian

---

Date

---

Family Insight Representative

---

Date



## Authorization to Transport

The following client, \_\_\_\_\_ has permission to be transported to and from activities by Family Insight staff members.

In addition, the following family members, with the guardian present may be transported:

- None  
 \_\_\_\_\_

This authorization is in effect only for the time that services are provided by Family Insight. I agree to release FI from liability resulting from an incident when providing transportation for the above-named client.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Family Insight Representative

\_\_\_\_\_  
Date



## Service Appeal Process

As a recipient of services, you have the right to appeal any change in treatment including the termination of services. Any appeal must be made in writing by notifying:

Appeals Division, Department of Medical Assistance Services  
600 East Broad St., Suite 1300  
Richmond, VA 23219

This written request for an appeal must be filed within thirty (30) days of termination. If you file an appeal before the termination date, services may continue during the appeal process. However, if the Appeals Division denies your appeal and you receive services after the termination date, you will be required to reimburse the Medical Assistance Program for services provided after the termination date.

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Signature of Client

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Date

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Signature of Parent/Guardian

---

Date

---

Family Insight Representative

---

Date



## Choice of Service Provider Form

I, \_\_\_\_\_, have been informed that there are other providers in my area, and I have chosen Family Insight, P.C. (FI). FI Mental Health Professionals provide services seven days a week and are available to respond to emergency situations outside of scheduled sessions. During your initial meeting with your Mental Health Professional(s), you will be given their cell phone numbers as well as those of their supervisor(s) so you can access them as needed to assist with urgent matters.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Family Insight Representative: \_\_\_\_\_ Date: \_\_\_\_\_



## Notice of Privacy Practices

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

Your health record contains personal information about you and your health. Family Insight, P.C. (FI) is committed to protecting this medical information. Upon request, we will provide you a copy of the full HIPAA regulations.

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:**

**For Treatment and health care operations**—To coordinate your treatment within our agency.

**For Payment**. FI may use or disclose medical information so that we can receive payment for the treatment services provided to you.

**Substance Abuse Information**. All medical information regarding substance abuse is kept strictly confidential and disclosed only in accordance with federal regulation (42 CFR part 2).

**As Required by Law**.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

**Abuse and Neglect**

**Emergencies**

**National Security**

**Judicial and Administrative Proceedings**

**Law Enforcement**

**Public Safety (Duty to Warn)**

**Verbal Permission**. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Family Insight Representative: \_\_\_\_\_ Date: \_\_\_\_\_



## YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your personal medical information maintained by our FI. To exercise any of these rights, please submit your request in writing to your Site Director \_\_\_\_\_ at \_\_\_\_\_:

- 1) **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy medical information that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- 2) **Right to an Accounting of Disclosures and to request restrictions.**
- 3) **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location'
- 4) **Right to a Copy of this Notice.** You have the right to a copy of this full Notice and the privacy regulations.
- 5) **Electronic Transactions Standards.** All electronic transmissions follow FI established security guidelines necessary to protect your confidentiality.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Family Insight Representative: \_\_\_\_\_ Date: \_\_\_\_\_



## Notice of Client Rights and Responsibilities

Each consumer has a right to exercise his/her legal civil, and human rights, including constitutional rights, statutory rights and the rights contained in this document, except where specifically limited. Your rights are assured and protected in the code of Virginia (12 VAC35-115). You have a right to know what they are and we will freely give you a copy, and review with you, the entire chapter in the code of Virginia detailing your rights, the complaint process and appeals process.

### In summary, it is your right to:

1. Be able to exercise your legal, civil and human rights related to the receipt of these services.
2. Receive services that are provided consistent with sound therapeutic practices.
3. To have your human dignity respected and be protected from harm, including abuse, neglect, exploitation, retaliation and humiliation.
4. Have access to your records and pertinent information in a timely manner to assist with making decisions regarding these services.
5. Receive prompt evaluation and person-centered treatment which includes you in the development of your individualized service plan.
6. Not be the subject of experimental or investigational research without your prior written and informed consent or that of your authorized representative.
7. Be treated under the least restrictive conditions consistent with your condition and not be subjected to physical restraint, isolation and seclusion beyond the constraints of our Handle with Care Non-Violent Restraint Intervention Policy.
8. Have access and be referred to legal entities for appropriate representation, self-help and/or advocacy support services.
9. You may file a complaint with your human rights advocate. Their role is to help protect your rights and to make sure you are being treated fairly.

Your Human Rights Advocate is: \_\_\_\_\_

### It is your responsibility to:

1. Attend as scheduled and participate fully and honestly in counseling and therapeutic service activities.
2. Remain available for appointments with their FI Mental Health Professional(s).
3. Refrain from the use of any abusive, vulgar, obscene, or demeaning language.
4. Refrain from any harassing, aggressive, threatening, or assaultive conduct towards others to include the use of weapons and/ or firearms.
5. Refrain from the use of illegal or legal substances to include drugs, tobacco, alcohol, or prescription medications during services.
6. Respect the property and right of others.

**An FI staff member has explained the foregoing rights and responsibilities to me, and I have read and understand them.**

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Family Insight Representative

\_\_\_\_\_  
Date



## Initial Service Plan

### PRIMARY IDENTIFIED NEEDS/PROBLEMS (IN CLIENT'S OWN WORDS-SNAP):

S  
N  
A  
P

#### 2. LONG TERM GOAL (IN CLIENT'S OWN WORDS):

#### 3. PRELIMINARY (SMART) OBJECTIVES:

- \_\_\_\_\_ will contact 911 or Family Insight Crisis Services at 1-866-841-7308 for further assistance if experiencing suicidal ideation, homicidal ideation or thoughts of self-harming behaviors, as needed for the first 30 days.
- \_\_\_\_\_ will utilize at least one symptom management strategy to assist with managing mental health symptoms as needed until the next scheduled therapy session (i.e Freeze, Relax, Evaluate, Decide-FRED) within the first 30 days of service.
- \_\_\_\_\_ will identify, link and engage with applicable collateral providers/community resources in order to comply with medical and/ or mental health recommendations (i.e medication compliance), for at least one occurrence in the first 30 days.

#### 4. INTERVENTIONS OF PRELIMINARY ISP:

- MHP will discuss proper safety precautions and review local Crisis contact information to utilize when \_\_\_\_\_ feels unsafe at the start of services and as needed for the first 30 days.
- MHP identify and discuss at least one symptom management strategy to assist with managing mental health symptoms as needed until the next scheduled therapy session (i.e Freeze, Relax, Evaluate, Decide-FRED) within the first 30 days of service.
- MHP will provide Care Coordination to identify, link and engage with applicable collateral providers/ community resources in order to comply with medical and/ or mental health recommendations (i.e medication compliance), for at least one occurrence in the first 30 days.

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Client

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Date

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Parent/Guardian

---

Date

---

Family Insight Staff Completing this Plan & Credentials

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Date

Client Name:  
Client #:

Updated 8.1.2020 v2.0

## Authorization for Release of Information

I, \_\_\_\_\_ (Client name or Representative), born on \_\_\_\_\_ (DOB) hereby authorizes Family Insight (FI) to exchange information with:

Name of individual and/ or organization: \_\_\_\_\_

Address/Phone Number: \_\_\_\_\_

For the purposes:(specify) \_\_\_\_\_

This information includes (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Records                     | <input type="checkbox"/> Neurological Evaluation                         |
| <input type="checkbox"/> Educational/Academic Records        | <input type="checkbox"/> Behavioral Reports                              |
| <input type="checkbox"/> Psychiatric Evaluation              | <input type="checkbox"/> Teacher Reports                                 |
| <input type="checkbox"/> Psychological Evaluation            | <input type="checkbox"/> Treatment/Discharge Summary                     |
| <input type="checkbox"/> Court Report                        | <input type="checkbox"/> Substance Abuse Evaluation                      |
| <input type="checkbox"/> An on-going exchange of information | <input type="checkbox"/> Past Services (Verbal Exchange or Reports)      |
| <input type="checkbox"/> Urine Screen/Breathalyzer Results   | <input type="checkbox"/> Permitted to sign Contact Logs to verify visits |
| <input type="checkbox"/> Other (describe below)              |  |

This authorization is valid from \_\_\_\_\_ to \_\_\_\_\_, unless revoked by the undersigned.

Date \_\_\_\_\_

Date \_\_\_\_\_

### Consent Signature(s)

Above Named Client	Date
Parent/Guardian/Authorized Representative	Date
Prepared and witnessed by FI Staff Member	Date

### Revocation Signature(s)

Above Named Client	Date
Parent/Guardian/Authorized Representative	Date
Prepared and witnessed by FI Staff Member	Date

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.



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 For the purposes:(specify) \_\_\_\_\_

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Parent/Guardian/Authorized Representative	Date
Prepared and witnessed by FI Staff Member	Date

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.



## Authorization for Release of Information

I, \_\_\_\_\_ (Client name or Representative), born on \_\_\_\_\_ (DOB) hereby authorizes Family Insight (FI) to exchange information with:

Name of individual and/ or organization: \_\_\_\_\_  
Address/Phone Number: \_\_\_\_\_  
For the purposes:(specify) \_\_\_\_\_

This information includes (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Records                     | <input type="checkbox"/> Neurological Evaluation                         |
| <input type="checkbox"/> Educational/Academic Records        | <input type="checkbox"/> Behavioral Reports                              |
| <input type="checkbox"/> Psychiatric Evaluation              | <input type="checkbox"/> Teacher Reports                                 |
| <input type="checkbox"/> Psychological Evaluation            | <input type="checkbox"/> Treatment/Discharge Summary                     |
| <input type="checkbox"/> Court Report                        | <input type="checkbox"/> Substance Abuse Evaluation                      |
| <input type="checkbox"/> An on-going exchange of information | <input type="checkbox"/> Past Services (Verbal Exchange or Reports)      |
| <input type="checkbox"/> Urine Screen/Breathalyzer Results   | <input type="checkbox"/> Permitted to sign Contact Logs to verify visits |
| <input type="checkbox"/> Other (describe below)              |  |

This authorization is valid from \_\_\_\_\_ to \_\_\_\_\_, unless revoked by the undersigned.

Date                      Date

### Consent Signature(s)

Above Named Client	Date
Parent/Guardian/Authorized Representative	Date
Prepared and witnessed by FI Staff Member	Date

### Revocation Signature(s)

Above Named Client	Date
Parent/Guardian/Authorized Representative	Date
Prepared and witnessed by FI Staff Member	Date

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## Telehealth Informed Consent

I/We, \_\_\_\_\_, consent to engage in telehealth and when allowed telephonic services, (e.g. psychotherapy, prescription refills, appointment scheduling, patient education, etc.); provided by Family Insight P.C. Telehealth services will occur through video communications via computer, tablet, webcam, and/or smart phone.

- 1) I/We have a right to know who is providing telehealth services and their credentials.
- 2) The Federal Confidentiality Rules (42 CFR Part 2) that protects the confidentiality of my personal health information also apply to telehealth services. As such, the information released by me during a telehealth session is generally considered confidential. There are both mandatory and permissive exceptions to this confidentiality including, but not limited to, reporting of child abuse, an expressed imminent harm to oneself or others, or as a part of a legal proceeding where information is requested by a court of law.
- 3) I/We accept responsibility for the confidentiality and privacy of the transmission medium and the environment from which I/We participate in services unless conducted at a Family Insight facility.
- 4) I/We understand it is my responsibility to ensure telehealth sessions are conducted in a private place.
- 5) I/We understand that there are risks and consequences in participating in telehealth including, but not limited to, the possibility, despite reasonable efforts on the part of Family Insight, that the transmission of information could be disrupted or distorted by technical failures.
- 6) I/We understand that the act of capturing photographs, audio, and/or video recordings by both provider and individuals present during the provision of services will be prohibited unless an expressed permission is granted in writing.
- 7) By signing this document, I/We understand that certain situations; including emergencies and crises are inappropriate for video/audio/computer-based services. If in crisis or in a situation of emergency, I/We should immediately call 911 or go to the nearest hospital or crisis facility. It is the role of the provider to determine whether the condition being diagnosed and/or treated is appropriate for a telehealth encounter.

By signing this document, have read and understand the information provided above with respect to telehealth services and have been informed that we may revoke our consent at any time.

Child/Client Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Family Insight Provider Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_



Weekly Contact Log: Week of \_\_\_\_\_ - \_\_\_\_\_

Client Name: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ Check One:  HBS  MHSB  IH Crisis Pvt Ins

Staff Name: \_\_\_\_\_ Lauris ID #: \_\_\_\_\_ Service Type: \_\_\_\_\_

(Please Print)

**TIME AND HOUR MUST BE FURNISHED PRIOR TO CLIENT SIGNATURE**

DATE, TIMES, AND HOURS MUST BE FILLED OUT PRIOR TO CLIENT SIGNATURE - TO CONFIRM SESSION DATE AND TIME				
Date: M/D/Y	Session Location: <i>Please be specific</i>	Time In: Time Out:	# Hours	Those Involved or/present  <i>Please do not leave blank</i>

Signature of  
Client/Parent/Guardian  
**DO NOT SIGN IF DATE AND  
TIMES ARE NOT FILLED OUT**

*"I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."*

*Staff Signature with Credentials:*



## RISK FOR FALL ASSESSMENT-ADULT

### Fall Risk Factor Category

Scoring not completed for the following reason(s) (check any that apply). Enter risk category (i.e. Low/High) based on box selected.

- Complete paralysis, or completely immobilized. Implement basic safety (low fall risk) interventions.
- Patient has a history of more than one fall within 6 months before admission. Implement high fall risk interventions throughout treatment.

COMPLETE THE FOLLOWING AND CALCULATE FALL RISK SCORE. IF NO BOX IS CHECKED, SCORE FOR CATEGORY IS 0.

POINTS

#### FALL HISTORY (SINGLE-SELECT)

- One fall within 6 months before admission (**5 points**)

#### ELIMINATION, BOWEL AND URINE (SINGLE-SELECT)

- Incontinence (**2 points**)
- Urgency or frequency (**2 points**)
- Urgency/frequency and incontinence (**4 points**)

MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS (SINGLE-SELECT)

- On 1 high fall risk drug (**3 point**)
- On 2 or more high fall risk drugs (**5 points**)
- Sedated procedure within past 24 hours (**7 points**)

PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCDS, ETC (SINGLE-SELECT)

- One present (**1 point**)
- Two present (**2 points**)
- 3 or more present (**3 points**)

#### MOBILITY (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)

- Requires assistance or supervision for mobility, transfer, or ambulation (**2 points**)
- Unsteady gait (**2 points**)
- Visual or auditory impairment affecting mobility (**2 points**)

#### COGNITION (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)

- Altered awareness of immediate physical environment (**1 point**)
- Impulsive (**2 points**)
- Lack of understanding of one's physical and cognitive limitations (**4 points**)

\*Moderate risk = 6-13 Total Points, High risk > 13 Total Points

Complete Falls Plan on ISP

Family Insight Representative: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Client Name:  
Client #:

Updated 8.1.2020 v2.0



Humpty Dumpty Falls Prevention Program™

## **Preventing falls, enhancing safety.**

### **Falls Assessment Tool The Humpty Dumpty Scale - Outpatient**

Parameter	Criteria	Score (circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male or Female under 3 years old	3
	Male over 3 years old	2
	Female over 3 years old	1
Diagnosis	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitations	3
	Forgets Limitations	2
	Oriented to own ability	1
Environmental Factors	History of Falls	3
	Patient uses assistive devices	2
	None	1
Medication Usage	Multiple usage of: Sedatives Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives/Diuretics Narcotic	3
	One of the meds listed above	2
	Other Medications/None	1
	TOTAL	

Rev: 09/2008

Date:
Name:
MR#:
Acct#:
D.O.B.:
Age:

#### Patient Falls Safety Protocol

##### Low Risk Standard Protocol (score 6-11)

- Orientation to room
- Environment clear of unused equipment, furniture's in place, clear of hazards
- Patient and family education available to parents and patient

##### High Risk Standard Protocol (score 12 and above)

- Identify patient with a "humpty dumpty sticker" on the patient, and in patient chart
- Educate patient/parents of falls protocol precautions
- Accompany patient with ambulation

**At risk for falls if score is 12 or Above**

Minimum Score 6

Maximum Score 19



## EPSDT

Dear Parents:

This letter is to inform you that your child is entitled to an EPSDT Early and Periodic Screening, Diagnosis, and Treatment preventive physical. This is a comprehensive physical examination, also known as a well child screening which your child's doctor should be aware of and includes the following:

- Complete physical examination
- Health history
- Vision and hearing assessments
- Age appropriate immunizations
- Minimal laboratory tests, **including lead screening**
- Annual referral to a dentist starting at age 3 - **Operation Smile**
- Appropriate referrals for other health problems detected

This is a great service covered by your insurance **if you have Medicaid**. If you have any questions regarding this information, please contact your **primary care physician**. If you have already had your child participate in this program, please call your MHP and arrange for a copy of the examination to be placed in his/her file.

Please sign below to indicate that this information has been discussed with you.

---

Signature of Client

---

Date

---

Signature of Parent/Guardian

---

Date

---

Family Insight Representative

---

Date



## EPSDT Authorization for Request for Information

I, (Client name or Representative), born on \_\_\_\_\_ (DOB) hereby authorizes Family Insight (FI) to exchange information with:

Name of individual and/ or organization:

Address/Phone Number:

For the purposes( specify): EPSDT Screening Documentation

**Please release the following pertinent medical information related to this client's EPSDT Early and Periodic Screening, Diagnosis, and Treatment preventive physical:**

This information includes (check all that apply):

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Health History                                | <input checked="" type="checkbox"/> Complete Physical Examination |
| <input checked="" type="checkbox"/> Vision/Hearing Screening                      | <input checked="" type="checkbox"/> Speech/Language Assessments   |
| <input checked="" type="checkbox"/> Lab Tests ( <b>including Lead Screening</b> ) | <input checked="" type="checkbox"/> Immunization Records          |
| <input checked="" type="checkbox"/> Referral to Other Health Providers as Needed  | <input checked="" type="checkbox"/> Annual Dentist Referral       |
| <input checked="" type="checkbox"/> Other (describe below)                        |   |

This authorization is valid from \_\_\_\_\_ to \_\_\_\_\_, unless revoked by the undersigned.  
Date                      Date

**Consent Signature(s)**

Above Named Client \_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian/Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Prepared and witnessed by: \_\_\_\_\_

**Revocation Signature(s)**

I \_\_\_\_\_ Revoke my consent for Family Insight to exchange information with the above-named PCP/Practice as of this date \_\_\_\_\_.

Above Named Client \_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian/Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Prepared and witnessed by: \_\_\_\_\_  
FI Staff Member

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## EPSDT Screening Documentation

NAME:

DOB:

CLIENT#:

(N) = Normal or (-) negative findings. Abnormal or positive findings must be documented/

AGE/DATE				
HT				
WT				
HC				
T P R				
FORMULA/DIET				
PERTINENT INTERVAL HISTORY				
EXAM				
Oral Inspection				
HEENT				
Chest				
Heart				
Gastrointestinal				
Genitourinary				
Musculoskeletal				
Endocrine				
Skin				
Lab				
Hematology (Hbg/Hct)				
Blood lead				
Urine				
Sickle Cell				
Other				
NUTRITION				
VISION SCREENING				
HEARING SCREENING				
SPEECH/LANGUAGE ASSESSMENT				
REFER TO DENTIST				
GROWTH AND DEVELOPMENT				
PERTINENT PROBLEMS/EXAM				
ABNORMALITIES				
IMPRESSION				
HEALTH EDUCATION AND ANTICIPATORY GUIDANCE				
REFERRALS				
NEXT SCREENING APPT.				

Name of Physician: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date of Screening:

Client Name:  
Client #:

Updated 8.1.2020 v2.0