Name____________________
DOB____________________
MRN#____________________

Southcentral Foundation's Behavioral Services Division
Dena A Coy Program

The following medical information form (or its equivalent) must be completed by your health care provider in order to participate in the Southcentral Foundation Program.

If there are any questions or concerns, please contact: ____________________

Name: ____________________ Date of Birth: ____________________

Does this patient have any detoxification needs prior to entering treatment?: ☐ No ☐ Yes

Are there any physical impairments/limitations: ____________________

Are there any communicable diseases: ____________________

Date of TB screening and results: ____________________

Is the patient pregnant?: ☐ No ☐ Yes EDC?: ____________________

PHYSICAL EXAMINATION

SYSTEM	NML	ABNML
HEENT		
Neck/Thyroid		
Heart		
Lungs		

SYSTEM	NML	ABNML
Abdomen		
Extremities		
Neurological		
Genital		

List known food, medication, or environmental allergies:

____

☐ This patient has been medically evaluated and cleared to participate in counseling, education, and/or activity groups for 5-6 hours a day.

☐ This patient has been medically evaluated and cleared to live in group care.

☐ This patient is medically cleared to participate in moderate aerobic and strength training exercises.

Name______________________
DOB______________________
MRN#_____________________

List all current prescription Medications:

Medication	Dose	Frequency & Route	Indication

If the patient is prescribed addictive or narcotic medications, are there non-narcotic alternatives? ☐ No ☐ Yes

If yes, please list____

☐ I have evaluated ______________________ and believe that this customer-owner is capable and competent to self-administer their own medications, as prescribed.

Provider Signature & Credentials ____________ Date ____________ Phone ____________

Provider Name Printed ____________

For Customer to Complete

I, ______________________, am able to self-administer the medications prescribed to me, including if needed, the physician approved over-the-counter medications above. I will be responsible to ask the staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting the medication I take at the time I take it on the "Self-Administration of Documentation form."

Customer Signature ____________ Date ____________

Healthcare Provider Approval for Adult OTC PRN Medication(s) Order Form

Provider: *Mark* **Yes or No for the following medication(s) to indicate your approval status**
☐YES ☐No **Acetaminophen** (Tylenol) 1000 mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER/MENSTRUAL CRAMPS Maximum 2000mg/24 hours ☐ Maximum 4000mg/24 hours ☐
☐YES ☐No **Ibuprofen** (Advil, Motrin) 400 mg by mouth every 4 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER
☐YES ☐No **Naproxen** (Aleve) 200 mg (220 mg tab) by mouth every 8 hours as needed for PAIN/MUSCLEACHE/HEADACHE/MENSTRUAL CRAMPS/FEVER
☐YES ☐No **Calcium Carbonate** (Tums) 1000 mg by mouth every 4 hours as needed for HEARTBURN
☐YES ☐No **Bismuth Subsalicylate** (Pepto-Bismol) 30 ml or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
☐YES ☐No **Docusate Sodium** (Colace) 100 mg by mouth two times daily as needed for CONSTIPATION.
☐YES ☐No **Anti-gas tablets** (Beano) 2 tablets by mouth before meals as needed for FLATULENCE/GAS
☐YES ☐No **Lactaid** 1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
☐YES ☐No **Multivitamin** take 1 tablet (or 2 gummy vits) by mouth daily as needed for NUTRITIONAL SUPPLEMENT
☐YES ☐No **Loratadine** (Claritin) 10 mg by mouth daily as needed for SEASONAL ALLERGIES
☐YES ☐No **Phenylephrine Hydrochloride** (Sudafed PE) 10 mg by mouth once daily as needed for SEASONAL ALLERGIES
☐YES ☐No **Oxymetazoline 0.05% solution nasal spray** (Afrin) 2 sprays each nostril 2 times a day as needed for NASAL CONGESTION
☐YES ☐No **Guaifenesin** (Robitussin) 10 ml by mouth every 4 hours as needed for COUGH
☐YES ☐No **Cough Suppressant** (Halls, cough drop) 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT
☐YES ☐No **Diphenhydramine hydrochloride** (Benadryl) 25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION. Consult health care provider if symptoms worsen or persist
☐YES ☐No **Diphenhydramine hydrochloride** (Benadryl) 50 mg by mouth at bedtime as needed for INSOMNIA. If used for 10 consecutive nights consult health care provider
☐YES ☐No **Nicotine lozenges** Week 1-6: 2 mg lozenge by mouth every 2 hours prn. Week 7-9: 2 mg lozenge by mouth every 4 hours prn. Week 10-12: 2 mg lozenge by mouth every 8 hours prn (as needed) for TOBACCO/CIGARETTE CRAVINGS. Do not chew.
☐YES ☐No **Benzocaine local anesthetics** (Orajel) apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN
☐YES ☐No **Topical antibiotic ointment** (Neosporin) apply thin layer to affected skin area 2 times daily as needed for MINOR SKIN ABRASION/CUT/SCRAPES
☐YES ☐No **Hydrocortisone acetate 1% cream** apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
☐YES ☐No **Clotrimazole 1%** (Lotrimin) apply thin layer to affected skin area 2 times daily as needed for ATHLETE'S FOOT/JOCK ITCH/RINGWORM
ALLERGIES:

I, ________________________________, am able to self-administer the medications prescribed to me, including if needed, the physician approved over-the-counter medications above. I will be responsible to ask the staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting the medication I take at the time I take it on the "Self-Administration of Medications Documentation form."

________________/________ ____________________
Customer-owner Signature & Initials Date

I have evaluated ______________________________ and believe that this customer-owner is capable and competent to self-administer their own medications, as prescribed. Please keep the above approved over-the-counter medications on file should it become indicated for the customer-owner to use for treatment of minor conditions while in the program. These orders are authorized for one year from the date of my signature, or until there has been a change in the customer-owner's condition that would affect their ability to self-administer their medications.

____________________________ ____________________
Provider Signature & credentials Date

____________________________ ____________________ ____________________________ ____________________
Customer-owner Name Date of Birth Phone number Fax number

MRN#______________________________

ANMC Mediset Medicaid Qualifications

________________________ has been referred to the ANMC Mediset
(patient name)

Program for the following reasons: (please check all that apply)

x Living in a congregate living home; or Dena A Coy

☐ Recipient of home and community-based waiver services; or

☐ Eligible for Medicaid due to a disability; or

☐ Is an adult experiencing a serious mental illness; or

☐ Is a child experiencing a severe emotional disturbance

I authorize mediset services for the below patient:

____
Patient name/DOB

____
Provider

Southcentral Foundation (SCF) – Behavioral Services Division (BSD)
4175 Tudor Centre Drive, Suite 200, Anchorage, Alaska 99508
Health Information Management Phone: 907-729-6380 Fax: 907-729-5188

Authorization to Release Health Information

Name of Customer/Owner whose information is to be released:	Customer/Owner Date of Birth:	Medical Record #:
Name of Parent or Legal Guardian, if applicable: (required for minors)	Customer/Owner Contact Information (or legal representative, if applicable):	

I authorize SCF – BSD to ☐ RELEASE Information To and/or ☐ OBTAIN Information From

Person/Organization: ______________________

Address: ______________________

City/State/Zip Code: ______________________

Main Phone Number/Fax Number: ______________________

How would you like to receive these records: ☐ By Fax ☐ By Mail ☐ Walk In / Pick Up

Description of Specific Information to be disclosed: *(please check all that apply)*

☐	Assessments	☐	Complete Health Record	☐	Discharge Summaries
☐	Education Records	☐	Medication Lists	☐	Pharmacological Management Notes
☐	Group Notes	☐	Therapy Notes	☐	Transfer Summaries
☐	Treatment Plans/Treatment Plan Reviews	☐	Written and / or Verbal Communication	☐	Other:
☐	Behavioral Health Consultants Documentation from ANMC				
☐	Other:				
☐	Other:				

Service Date (From): ____________ Service Date (To): ____________ or Information Pertaining To: ____________

Specific purpose of this release of information: *(please check the best description)*

☐ Coordination of Care ☐ Personal Use ☐ Legal Use ☐ Emergency Contact ☐ Other: ____________

I understand that authorizing the disclosure of the above information is voluntary and I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric and mental health care, or other sensitive information. I understand that if I am seeking Behavioral Health Services, that the entity seeking this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that if I am seeking Drug and Alcohol Services subject to 42 C.F.R Part 2, that the entity seeking this authorization is not permitted to condition treatment, payment, enrollment or eligibility for benefits on the provision of a 42 C.F.R Part 2 compliant release for treatment purposes. I understand that I have the right to revoke this authorization at any time except to the extent that information has already been released. Authorizations for the release of alcohol and drug abuse records protected by 42 C.F.R. Part 2 can be revoked verbally. Authorizations covering all other health information must be revoked in writing. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that health information released, if covered by federal law 42 C.F.R. Part 2 (Alcohol & drug abuse records); will continue to be protected by law from re-disclosure. I understand that information only covered by HIPAA (45 C.F.R. Parts 160 & 164) is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Act. I understand that there may be a fee for copying associated with this request. I hereby authorize the use or disclosure of the health information as described above.

Expiration Date or Event: ______________________ (Unless otherwise specified, this authorization will expire one year from signature date)

____
Signature of Customer Signature Date

____
Signature of Parent / Legal Representative, if applicable Signature Date

REVOCATION SECTION: This section should NOT be completed when the authorization is initially signed. This section should <u>only</u> be completed <u>if</u> the client wishes to revoke authorization.

I hereby request that this authorization to release information be revoked; effective on the date of my signature below.

____
Signature of Customer-Owner / Parent / Legal Representative Signature Date
If Customer-Owner revokes verbally, staff will enter their name and job title followed by the date the staff received the revocation instructions

Office Use Only: Received from Facility: ________ By Employee: ________

Revised 09/19/16