



PHOENIX PROGRAM INTAKE SHEET

Client's Name: _____

Social Security Number: _____ Date of Birth: _____ Sex: M F

Ethnicity: _____ Religion: _____

Date of Placement: _____ Placement Location: _____

Place of Birth: _____ Medicaid #: _____

Current Medications _____

Allergies: _____

Significant Health Conditions: _____



PHOENIX PROGRAM

APPROVED VISITORS AND PHONE CALLS

Client's Name: _____

Correctional Facility: _____ PO: _____

Office #: _____ Cell#: _____ Email: _____

NAME	RELATIONSHIP	PHONE	LOOSELY MONITOR	CLOSELY MONITOR	NO MONITOR	OFF GROUNDS

*** Please include anyone able to have contact including siblings, relatives, professionals, etc.

Prohibited List:

TREATMENT RECOMMENDATIONS

Please only utilize this form if applicable

Client's Name: _____

Desired Focus of Treatment:

_____ Excessive Dependency

_____ Withdrawal / Isolation

_____ Parent / Child Relationships

_____ Peer Relationship

_____ Acceptance of Authority

_____ Sexual Appropriateness

_____ Excessive Eating

_____ Lying

_____ Enuresis

_____ Stealing

_____ Self-destructiveness

_____ Delayed Social Development

_____ Poor Self-Esteem

_____ Manipulative

_____ Low Frustration Tolerance

_____ Property Destruction

_____ Hyperactivity

_____ Anxiety

_____ Verbal Aggression

_____ Assault

_____ Depression

_____ Avoidance

_____ Impulsiveness

_____ Poor Academic Achievement

_____ Other _____

Diagnostic History:

Psychiatric Evaluation? Yes No

Psychological Evaluation? Yes No

Name of Evaluator

Address

Phone

Date of Evaluation

MEDICAL HISTORY

Condition	Client	Mother	Father	Sibling	Sibling	Sibling
Alcoholism	Y N	Y N	Y N	Y N	Y N	Y N
Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Anemia	Y N	Y N	Y N	Y N	Y N	Y N
Arthritis	Y N	Y N	Y N	Y N	Y N	Y N
Asthma	Y N	Y N	Y N	Y N	Y N	Y N
Cancer	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N	Y N	Y N	Y N
Hearing Problems	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Hemophilia	Y N	Y N	Y N	Y N	Y N	Y N
Hypertension	Y N	Y N	Y N	Y N	Y N	Y N
Kidney Disease	Y N	Y N	Y N	Y N	Y N	Y N
Malformation	Y N	Y N	Y N	Y N	Y N	Y N
Malnutrition	Y N	Y N	Y N	Y N	Y N	Y N
Mental Retardation	Y N	Y N	Y N	Y N	Y N	Y N
Obesity	Y N	Y N	Y N	Y N	Y N	Y N
Sickle Cell Anemia	Y N	Y N	Y N	Y N	Y N	Y N
Substance Abuse	Y N	Y N	Y N	Y N	Y N	Y N
Tuberculosis	Y N	Y N	Y N	Y N	Y N	Y N
Ulcers	Y N	Y N	Y N	Y N	Y N	Y N
Venereal Disease	Y N	Y N	Y N	Y N	Y N	Y N
Vision Problems	Y N	Y N	Y N	Y N	Y N	Y N

List other major health considerations of physical limitations: _____



**AUTHORIZATION FOR THE USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Resident Name

Date of Birth

Date of Admission

I hereby freely and voluntarily authorize Transitions for Life to:

- Release/disclose records of my health information to:
 Obtain records of my health information from:

Individual, Facility, Organization

Telephone Number

Address

City, State

Zip

The purpose for this disclosure is:

- To assist in funding
 To assist in treatment planning
 To keep the above informed of resident's progress
 To assist in educational placement
 To coordinate discharge planning/placement
 Other (specify) _____

This information to be released/ obtained includes:

- Discharge Summary
 Lab, X-Rays, EEG, EKG
 Psychological Testing
 Educational Assessments/ Testing/ Evaluations and Records
 Treatment Plans
 History and Physical
 Immunization Record
 Psychiatric Evaluation
 Verbal exchange of information
 Substance Abuse Treatment
 Other (specify) _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not rediscover them to anyone else without my separate written consent unless such recent is a provider who makes a disclosure permitted by law. **This consent expires on (date: month/day/year)**_____.

Client Signature

Print Name

Date



RIGHTS OF RESIDENTS

Each person who receives services from Transitions for Life shall be assured of his/her legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of Transitions for Life and is consistent with sound therapeutic treatment. Each person

1. Retain his/her legal rights as provided by state and federal law;
2. Receive prompt evaluation and treatment or training about which he/she is informed in so far as he/she is capable of understanding;
3. Be treated with dignity as a human being and be free from abuse;
4. Not be the subject of experimental or investigational research without his/her prior written and informed consent or that of his/her legally authorized representative;
5. Be afforded an opportunity to have access to consultation with a private physician at his/her own expense, and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his/her health;
6. Be treated under the least restrictive conditions consistent with his/her condition and not be subjected to unnecessary physical restraint and isolation;
7. Use his/her preferred name;
8. Have access to his/her medical and mental records and be assured of the confidentiality but, notwithstanding other provision of law, such right shall be limited to access consistent with his/her condition and sound therapeutic treatment;
9. Have the right to an impartial review of violations of the rights assured under this section and the right of access to legal counsel.
10. To be accorded safe, healthful, and comfortable accommodations, furnishings and equipment to meet his/her needs;
11. To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with the daily living functions, including eating, sleeping, or toileting, or withholding of shelter, clothing, medication or aids to physical functioning.
12. To be informed and to have the authorized representative informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the licensing agency's complaint receiving unit, and of information regarding confidentiality;
13. To be free to attend religious services or activities of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis;
14. To leave or depart the facility at any time, except for house rules for the protection of clients,
15. Not to be put in any room, building, or facility premises by day or night where he/she cannot readily open the door;
16. Not to be placed in restraining devices;
17. To visit the facility with his/her relatives or authorized representative prior to admission;
18. To have his/her relatives or authorized representative regularly informed by Transitions for Life of

activities related to care and supervision.

19. To have communications from his/her relatives or authorized representative answered promptly and completely;
20. To have visitors, including advocacy representatives, visit privately during waking hours provided such visitations do not infringe upon the rights of other clients, unless prohibited by court order or the authorized representative;
21. To wear his or her own clothes, to possess and control his/her own cash resources, to possess and use his/her own personal items, including his/her own toilet articles;
22. To be able to display personal items where appropriate; i.e., living space
23. To have access to individual storage space for his/her private use;
24. To participate in treatment planning at age and developmental level.
25. To have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of telephone in emergencies;
26. To mail and receive unopened correspondence unless prohibited by court order or by the authorized representative and for children to have ready access to letter writing materials and stamps;
27. To receive assistance in exercising the right to vote;
28. To move from Transitions for Life transitional homes in accordance with the terms of the admissions agreement.

I, the undersigned, have read, or had read to me, understand, and have received a copy of the Rights of Residents.

Client's Signature

Client's Name Print

Date