



## TITAN 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: \_\_\_\_\_





## 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

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## MEDICAL HISTORY

<b>Condition</b>	<b>Client</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Sibling</b>	<b>Sibling</b>
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.**

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Client's Signature

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Client's Name Print

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Date