Hospice Outreach Programs of Elgin

H -Holistic Support / O -Outreach Services / P –Programs With Compassion / E –Educational Resources

Therapeutic Art Youth Intake Form

URGENCY ___/10

Youth Information:

First Name_____ Last Name_____ Age: _____

DOB: _____ Address: _____

School attended _____ Grade _____

Hobbies and Interests: _____

_____

Have there been significant changes / stresses in your child's life (i.e. divorce, remarriage, relocation, Death, illness(es))?

_____

_____

Please explain how your child shows that he/she is grieving/hurting (sadness, anger, acting out, etc).

_____

_____

How did you hear of our program? _____

_____

Your expectations of the program for your child are: _____

_____

Please list any additional info that will help us provide a better experience for your camper:

_____

_____

Has your child received any support? (i.e. school, pastoral care, hospice support, Therapy etc.) Yes / No

If Yes, please explain (and has it ended): _____

_____

Please provide all Providers and Services Currently involved: (if known)

Name	Phone	Fax
Family Physician:		
Other:		

What are the best times and days available for appointments? Please check all that apply

( ) Mornings (8-11 am)
( ) Afternoons (12-4 pm)
( ) Evenings (5-8 pm)
( ) Monday
( ) Tuesday
( ) Wednesday
( ) Thursday
( ) Friday
( ) Saturday (AM or Afternoon)
( ) Other: _____

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226-721-5901 Toll Free-1-888-389-3655

TERMS AND CONDITIONS

BEFORE SUBMITTING THIS FORM AND UTILIZING THE MANY SUPPORT SERVICES OF HOSPICE OUTREACH PROGRAMS OF ELGIN (HOPE) PLEASE READ THESE TERMS AND CONDITIONS CAREFULLY. YOU FULLY UNDERSTAND THAT ONGOING USE OF HOPE'S SERVICES INDICATES THAT YOU AGREE TO THE TERMS AND CONDITIONS SUMMARIZED BELOW.

DISCLAIMER: SERVICES PROVIDED BY HOPE ARE NOT A SUBSTITUTE FOR MEDICAL ADVICE OR TREATMENT.

CONFIDENTIALITY: YOUR PERSONAL INFORMATION (AS ON THIS INTAKE FORM), AS WELL AS THE CONTENT OF YOUR CONSULTATION SESSIONS WITH A REPRESENTATIVE REPRESENTING HOPE, MAY BE USED IN CASE OF AN EMERGENCY SITUATION ONLY. IN ORDER TO KEEP YOU AND THE COMMUNITY SAFE. WE OFFER CONFIDENTIALITY IN OUR SESSIONS. THIS MEANS THAT WHATEVER YOU SAY IN OUR SESSION WE WILL NOT TELL OTHERS WITHOUT YOUR PERMISSION

EXCEPT FOR THREE CONDITIONS:

- YOU HAVE A PLAN TO HARM YOURSELF OR SOMEONE ELSE. (THIS MEANS THAT YOU HAVE PLANNED OUT THE EXACT SITUATION WHERE SOMEONE CAN GET HURT, WE HAVE A DUTY TO REPORT THAT.)
- YOU SHARE A PAST OR PRESENT CASE OF CHILD ABUSE THAT HAS NOT YET BEEN REPORTED.
- WE GET COURT SUBPOENAED, WHICH MEANS THE COURT REQUESTS DOCUMENTS OF OUR SESSIONS WITH YOU.

COMMUNICATION OF PRIVATE MENTAL HEALTH INFORMATION

PLEASE (√) ALL ACCEPTABLE FORMS OF COMMUNICATION TO PROVIDE QUALITY CLIENT CARE:

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO LEAVE A MESSAGE REGARDING MY PRIVATE INFORMATION ON MY PERSONAL VOICEMAIL/ANSWERING MACHINE.

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO SEND WRITTEN COMMUNICATION TO MY HOME OR EMAIL ADDRESS.

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO SHARE INFORMATION WITH OTHER HEALTH CARE PROFESSIONALS I MAY BE ASSOCIATED WITH, NOW OR IN THE FUTURE, IF HELPFUL TO MY CARE.

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT AND HEREBY GIVE AUTHORIZATION FOR THE RELEASE OF INFORMATION BY THE ACCEPTABLE MEANS CHECKED ABOVE.

PAYMENT: THERE IS NO CHARGE FOR OUR SERVICES. DONATIONS ARE APPRECIATED, BUT NOT REQUIRED.

CHILD'S PARENT/LEGAL GUARDIAN RELATIONSHIP TO CHILD _____

FIRST NAME _____ LAST NAME _____

ADDRESS: _____

MOBILE PHONE _____ OTHER PHONE _____

SIGNED:_____ Date: _____

Client signature or Parent/Guardian signature (if client is a minor or under 12 years of age)