CHESTNUT HEALTH SYSTEMS
chestnut.org

Re: Assessment for Chestnut Health Systems Substance Use or Mental Health Services

Dear Sir or Madam:

As mentioned when you scheduled your assessment appointment with Chestnut Health Systems, it is important that you please review the attached documents prior to your scheduled phone assessment with your counselor.
Included are two separate packets, one is for you to please complete and return, the second packet is for you to keep for your information.
We have provided a pre-stamped self-addressed envelope for your convenience.

Please also review the key points below for your scheduled call.

Your scheduled assessment information

DATE	Day:	Date:
TIME		☐AM ☐PM
COUNSLEOR		

Key points to remember:

- Your counselor will be calling you from a private number, so the call may show as blocked or unknown. Please be prepared to answer a call that comes into your phone at your scheduled time.
- The counselor will attempt to call your number on file three times at the beginning time of your scheduled appointment; with the third call at five (5) minutes after your scheduled time.
- Since there will be personal questions asked of you, it is ideal that you find a private location to complete your assessment appointment.
- If you need to cancel or reschedule, please call 309-827-6026

Thank you,

Chestnut Health Systems

1003 Martin Luther King Jr. Drive
Bloomington, Illinois 61701

Phone: (309) 827-6026

CHESTNUT HEALTH SYSTEMS

INFORMED CONSENT / CONSENT TO TREATMENT

We thank you for choosing Chestnut Health Systems, Inc. for your treatment services. At Chestnut we strive to equip people with the tools they need to meet challenges and improve their quality of life. This document contains important information about your treatment services at Chestnut. Please ask questions about anything you do not understand.

INFORMED CONSENT

Behavioral healthcare services have benefits and risks. Treatment services can help you learn about yourself, manage your life and relationships, gain and maintain hope and a sense of well-being, and have various other positive effects on your life. However, because treatment services often involve working through difficult aspects of your life, you may experience uncomfortable feelings such as sadness, anger, guilt, frustration, or other difficult emotions.

Your first visit(s) will involve an assessment of your needs, followed by recommendations for your treatment. You will then work with Chestnut staff to develop a treatment plan that will outline your goals for treatment and a plan for achieving them. Your regular attendance and active participation is essential in order to obtain maximum treatment benefits.

CONSENT TO TREATMENT

I am voluntarily seeking services from Chestnut for the purposes of behavioral health diagnosis and treatment and hereby consent to such diagnostic procedures and treatment as may be deemed necessary for myself or, in my capacity as legal guardian, for the patient. I understand that Chestnut's facilities are not locked treatment facilities. I acknowledge that sufficient information concerning the nature and purposes of Chestnut treatment programs, its procedures, and methods of treatment have been explained to me in order for me to make an informed decision about my treatment. I authorize Chestnut staff to determine the treatment methods necessary for me to be successful in treatment.

I understand that my health information may be accessible to Chestnut employees in the course of their duties, whether or not I am an employee or family member of a Chestnut employee or have a personal relationship with a Chestnut employee. Employee or family member health information will be treated the same as other health information received by Chestnut.

I understand that I have the right to give or withhold informed consent regarding treatment. I understand that while I may withdraw my consent to treatment at any time, if I do so, I will be discharged from services.

My signature below is acknowledgment that I have received, read and understand this Informed Consent/Consent to Treatment document and I hereby voluntarily consent to treatment at Chestnut.

Signature of Client and Date (required for clients age 12 & older)	Signature of Guardian and Date (parent or legal guardian, as applicable)
Witness Signature and Date	Signature of Family Member and Date (optional)

Client Name:	Client ID:

CHESTNUT HEALTH SYSTEMS

Financial Intake Information

Please print and complete all boxes.

Date Completed: _____ Chestnut Staff Member: _____

Client Last Name	Client First Name			Client Middle Name
Mailing Address	City	State	Zip Code	County

Home Telephone permission to call	Work Phone permission to call	Cell Phone permission to call
Gender: ☐ Male ☐ Female	Date of Birth	Social Security Number
Marital Status: Never Married Married Widowed Divorced Separated Re-married	Ethnic Background (Race)	Driver's License Number

How were you referred to Chestnut?

Newspaper Ad Newspaper Article Radio Ad Radio News TV Ad TV News Word of Mouth (Family or Friends)

Yellow Pages Website Internet Ad Direct Referral Only (please specify) _____

Other (please explain)

Client Employment Information:

Unemployed Part-Time Full-Time Retired Home Maker Seasonal Worker Full-Time Student Leave of Absence	If Employed: Employer Name and Address
Length of Current Employment Status:	
Source of Income: Wages Alimony SSI/Disability Child Support Other:	Annual Income: $
Legal status: none on Court Supervision on probation on parole pending	

Responsible Party Information: (Complete only if client is a minor child.)

Responsible Party Name	Responsible Party DL#: State of DL#:
Responsible Party Address	City, State, Zip Code
Responsible Party Gross Family Income (Annual) $	Number of Dependents:

Relationship to Client: Mother/Maiden Name: Father Sister Brother Aunt Uncle Grandmother Grandfather State Appointed Other:

Mothers Employer Name and Address	Home Phone Number	Mother's Work Number
	Cell Phone Number	Mother's Social Security Number
Fathers Employer Name and Address	Home Phone Number	Father's Work Number
	Cell Phone Number	Father's Social Security Number

(For Office Use Only)

Client Name	Client Number

Insurance Information

(Please provide us with a photocopy of your card/cards.)

	Primary Insurance Information	Secondary Insurance Information
Insurance Company Name		
Insurance Company Telephone Number		
Insurance Policy Number		
Group Number		
Policyholder Name (Last Name, First, Middle)		
Policyholder Social Security Number		
Policy Holder Telephone Number		
Policyholder Address		
Policyholder City, State, Zip Code		
Policyholder Date of Birth		
Policyholder Employer	Parent Spouse Step-Parent Other:	Parent Spouse Step-Parent Other:
Policyholder Relationship to Client		

In case of an emergency, whom may we contact for you?

Name	Address	City, State, Zip Code
Relationship to Client: Mother Father Sister Brother Aunt Uncle Grandmother Grandfather State Appointed Spouse Other:		
Home Telephone Number:	Work Phone Number:	Cell Phone Number:

(For Office Use Only)

Client Name	Client Number

Responsibility for Payment

Initial: _____

Chestnut Health Systems participates with several major insurance companies as well as Federal, State and local payors. If you provide your current insurance card(s) and information at your visit we will bill your insurance company as a courtesy to you. We encourage every patient to understand their medical benefits. If you need further clarification, please contact your insurance company directly. Benefits quoted or services authorized by your insurance company do **not** guarantee payment for services. You will be responsible for any required co-pays, co-insurance, and deductibles identified by your insurance plan or other payers. Once your claim has been processed by your payer, any remaining balance will be billed to you.

CHESTNUT HEALTH SYSTEMS

Physical Health Assessment

Date: **Patient Name**: **Patient ID**:

Date of Birth: **Age**:

Do you have allergies to medicines? ☐ Yes ☐ No If yes, list:

Do you have other allergies? ☐ Yes ☐ No If yes, list:

List all current <u>non-psychiatric</u> prescribed or over-the-counter medications including herbals, vitamins and other supplements. ☐ None		**List current <u>psychiatric</u> medications.** ☐ None
List any medications you stopped using within the past month. ☐ None		**List past <u>psychiatric</u> medications.** ☐ None

Do you have a primary care provider (doctor, physician's assistant, Advanced Practice Nurse)? ☐ Yes ☐ No

If yes, name:

Address: Phone:

Date of Last Physical: Date of Last Visit:

Do you have a dentist? ☐ Yes ☐ No

If yes, Name: Date of Last Visit:

Do you have current dental problems? ☐ Yes ☐ No If yes, please describe:

Do you have a psychiatrist? ☐ Yes ☐ No

If yes, Name: Date of Last Visit:

Address: Phone:

Please list any hospitalizations you have had for major injuries, surgeries or medical illnesses and the dates they occurred (**do not** include hospitalizations related to mental health or substance abuse). ☐ None

Height: **Weight**:

Has your weight changed in past six months? ☐ Yes ☐ No If yes, answer the next 3 questions.

(1) Was the weight change intentional? ☐ Yes ☐ No **(2)** If you've had weight change, what did you weigh 6 months ago?

(3) What did you weigh 1 month ago?

Do you use tobacco? ☐ Yes ☐ No If yes, what kind:

How much per day? How many years have you been using tobacco products?

Are you currently pregnant or have you delivered a baby within the past 6 weeks? ☐ Yes ☐ No

If yes, date of last OB-GYN visit:

Have you been bothered by physical pain within the past month? ☐ Yes ☐ No

If yes, where?

Has this pain lasted for 6 months or longer? ☐ Yes ☐ No

Please rate any current pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Please indicate whether you have any of the following health issues by checking ALL boxes that apply next to and filling in any other information asked.

HEALTH ISSUES	**No Current or Past Problem**	**Experienced during the Last Year**	**Currently Undergoing Treatment**	**History of Problem (1+ year ago)**	**Family History**
Alcohol / Drug	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Deforming Arthritis	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐
Breathing Problems (Asthma, Emphysema, etc.)	☐	☐	☐	☐	☐
Cancer—*List Type*	☐	☐	☐	☐	☐
Diabetes *Insulin Dependent* ☐ Yes ☐ No	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Gynecological Problems (female)	☐	☐	☐	☐	☐
Head Injury with/without Loss of Consciousness	☐	☐	☐	☐	☐
Hearing Problems	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Liver Disease *(hepatitis, cirrhosis)*	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐
Motor Problems (walking/balance)	☐	☐	☐	☐	☐
Neurological Problems (migraine, numbness, tingling)	☐	☐	☐	☐	☐
Open Wound or MRSA	☐	☐	☐	☐	☐

Patient Name: **Patient ID**:

HEALTH ISSUES (continued)	No Current or Past Problem	Experienced during the Last Year	Currently Undergoing Treatment	History of Problem (1+ year ago)	Family History
Seizures	☐	☐	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐	☐	☐
Skin Problems	☐	☐	☐	☐	☐
Special Dietary Needs—*List Type:*	☐	☐	☐	☐	☐
Speech or Language Problems	☐	☐	☐	☐	☐
Stomach Problems	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐
Vision Problems	☐	☐	☐	☐	☐
Other Health Problem(s):	☐	☐	☐	☐	☐

Describe Any Special Needs:

If you are 17 and under, are your immunizations up-to-date:

☐ Yes ☐ No If no, please explain:

TUBERCULOSIS SYMPTOM CHECKLIST	Yes	No	If Yes, Please Explain
Persistent Productive Cough – Greater than 3 weeks			
Night Sweats			
Loss of Appetite			
Unexplained Weight Loss (Not trying to lose)			
Extreme Fatigue			
Shortness of Breath			
Persistent Fever Chills			
Chest Pain – Greater than 15 days			
Coughing up Blood**			

Have you ever been tested for Tuberculosis (TB)? ☐ Yes ☐ No

If yes, date and location of last ☐ TB skin test or ☐ Chest X-Ray:

Results of test: ☐ Positive ☐ Negative

If Positive, describe follow-up care:

Patient Name: **Patient ID**:

HIV/AIDS/HEPATITIS RISK ASSESSMENT

We provide each patient with information about HIV/AIDS and Hepatitis C testing.
Please answer the questions below that address behaviors that may put you at risk of contracting HIV/AIDS or Hepatitis C.

☐ ***Please check here if you prefer to answer these questions with the person who is completing your intake.***

Do you have any homemade tattoos or ear piercings?	☐ Yes ☐ No
Have you injected any drugs?	☐ Yes ☐ No
Have you ever had sex without using a condom or barrier to protect you and your partner from disease?	☐ Yes ☐ No
Have you had sex with more than 2 sexual partners?	☐ Yes ☐ No
Have you had sex with an IV drug user or known HIV positive person?	☐ Yes ☐ No
If yes to any of the above, have you been tested for HIV/AIDS/HepC***	☐ Yes ☐ No
If yes, when:	

**************PATIENT STOP HERE*************

RECOMMENDATIONS MADE BY STAFF

Outpatient and Community Based Services: If the patient: • <u>has not had a physical</u> within the last 12 months, or • identified a current medical problem and <u>is not currently undergoing treatment</u>, or • has experienced current pain or pain for more than 6 months: ☐ **We recommend patient see a primary care provider.** (Staff to provide referral list of FQHC clinics or other resources for primary care treatment.) If patient is pregnant and not seeing a doctor: ☐ **We recommend patient see an OB/GYN for prenatal care.**	Information found on page 1, first set of questions. Page 2, column 2 checked, column 3 unchecked.
Residential Services: (Physical is performed by a prescriber.) ☐ **CD –** Patient is on prescription medication or pregnant; physical is required within 72 hours after admission. ☐ **CD –** Physical is required within 7 days after admission. ☐ **MH –** Physical is required within 30 days after admission, or sooner if warranted as indicated by untreated health issues**.**	Page, 2, column 2 is checked AND column 3 is unchecked.

Nutritional Screening: If patient has a BMI under **18.5** or over **25 or** unexplained weight loss/gain of more than 20 pounds in 3 months for adults or 10 pounds in 3 months for children **or** medical condition impacting their nutritional health**:** ☐ **We recommend patient see a primary care provider.**	Use height and weight to locate and circle on BMI charts.* BMI: _____

Patient Name: **Patient ID**:

**** If the patient reported 3 or more symptoms of possible TB or patient reported coughing up blood, TB Skin Testing/TB Evaluation is required before patient can receive services. Referral options below:**

☐ **Madison County – 101 E Edwardsville Road, Wood River, Illinois 618-692-8954**

☐ **St. Clair County – 19 Public Square, Suite 150, Belleville, Illinois 618-233-7703**

☐ **McLean County – Schedule with Chestnut Health Systems' nursing staff prior to admission to treatment.**

***** If the patient reported yes to 1 or more high risk behaviors associated with HIV/AIDS/Hepatitis C risk and has not been tested:**

☐ **We recommend patient to be tested. (Staff to provide referral list of public health offices.)**

☐ **No Recommendations** (Patient has had a physical within the past 12 months and has no untreated health issues).

Note: Any medical issue that may impact treatment will be addressed in the Treatment/Recovery Plan.

☐ I have received and understand the recommendations.

☐ I understand I **must** be tested for TB (see referral options above). Staff must receive results before I can receive services. (Staff to obtain release of information and facilitate referral.)

Patient Signature	*Date*
Staff Signature	*Date*
Parent/Guardian Signature	*Date*
Reviewing Nurse Signature (Crisis Residential Only)	*Date*

*Using the BMI charts (adult or child), find and circle the current BMI. Attach the chart to the Physical Health Assessment.

PHYSICIAN'S REVIEW FOR CD AND CRISIS RESIDENTIAL PATIENTS

☐ **Physician's Review Not Recommended**. Staff initials:

☐ **Physician's Review recommended for the following reasons**: (For CD Level III this is required within 48 hours of admission, and for Levels I and II within 72 hours of admission)

☐ Patient taking medications on the "Contraindicated for Use in Residential Chemical Dependency Treatment" list.

☐ Residential patient discontinued taking any medications in past two weeks without doctor's orders to discontinue.

☐ Other Immediate medical or psychiatric concern. Specify:

Physician's Recommendations:

Name of Physician Contacted:

Staff who Contacted Physician: **Date:**

Patient Name: **Patient ID**:

CHESTNUT HEALTH SYSTEMS

Chestnut Health Systems' Notice of Privacy Practices and Patient Rights

Receipt and Acknowledgment of Notice

Patient Name: _____

I hereby acknowledge that I have received and understand Chestnut Health Systems' Patient Rights. I have also been informed of Chestnut's Notice of Privacy Practices. I understand that if I have any questions regarding the Privacy Practices or my rights, I can contact:

Privacy Officer
1003 Martin Luther King Drive
Bloomington, IL 61701
309.827.6026
OR
privacy@chestnut.org

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Guardian or Personal Representative* Date

* *If you are signing as a personal representative of a Patient, please describe your legal authority to act for this individual (power of attorney, health care surrogate, etc.):*

☐ ***Patient Refuses to Acknowledge Receipt**:*

I acknowledge that I provided the patient with a copy of their Patient Rights and informed them of the Notice of Privacy Practice.

_____ _____
Signature of Staff Member if Patient Refuses to Sign Date