

Pine Grove Outpatient Services

Inquiry Call Information

APPT DATE: ____/____/____ **APPT TIME** ____/____/____ **PROVIDER:** _____

Caller Information:

Date of Call: ____/____/____ Staff Member taking call: _____ Service of Interest: _____

Caller First Name: _____ Caller Last Name: _____ Caller Phone #: _____

Intake Information:

1. What is reason for calling? Evaluation Testing Therapy Medication Other Group or Program Interest

1A. Please indicate Chief Complaint or Primary Concern: _____

2. Does patient have current legal issues pending? Yes No **If yes, please explain:** _____

3. Has patient ever been seen at Pine Belt Mental Health? Yes No **If yes, last date seen:** ____/____/____

4. Is patient in the process of applying for any type of Disability Determination? Yes No

Patient Information:

Parent's Name: _____ Patient's Name: _____

Pt's Date of Birth: ____/____/____ Pt's Age: _____ Pt's SSN: ____/____/____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone#: ____/____/____ Cell Phone#: ____/____/____ Other Phone#: ____/____/____

Referral Source Information:

How did you hear about our services?

Professional Media Family Friend FGH/PG Employee Pt. is a former Pt. of _____

If Professional: First and Last Name of Professional: _____

Professional Organization: _____ Professional Phone #: _____

Release of Information signed for professional? ____ Yes ____ No **If Yes:** Release signed on: ____/____/____

If Media:

PG Website Yellow Pages Newspaper TV Radio Media- Other Print Internet Search

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Primary Insurance Phone #: ____/____/____ Secondary Insurance Phone #: ____/____/____

Primary Ins. Policy Holder: _____ Secondary Ins. Policy Holder: _____

Primary Ins. Policy ID#: _____ Secondary Ins. Policy ID#: _____

Pri. Ins. Group #: _____ Eff. Date: ____/____/____ Sec. Ins. Group# : _____ Eff. Date: ____/____/____

Was caller made aware of the following:

Cancellation and No Show Policy

Staff Initials: ____ Date: ____/____/____

Payment Policy

Staff Initials: ____ Date: ____/____/____

If patient is minor, was caller informed someone would be calling them within 7 days of the appointment date to gather additional information?

Staff Initials: ____ Date: ____/____/____

Pine Grove Outpatient Services

Patient Triage Information

APPT DATE: ____/____/____ **APPT TIME** ____/____/____ **PROVIDER:** _____

Caller Information:

Date of Call: ____/____/____ Staff Member taking call: _____ Service of Interest: _____

Caller First Name: _____ Caller Last Name: _____ Caller Phone #: _____

Referral Question (As understood by Parent and Chief Complaint. What are the parents concerned about?) _____

Are the parents married or divorced? _____ If divorced, when? _____

Is there a custody issue? _____ Who has custody? _____

School _____ Type of Class Regular Special Education Other _____

Address of School _____ School Phone # _____

Teacher's Name: _____ Teacher's Phone # _____

Name of Pediatrician/Family Physician _____

Address: _____ Phone #: _____

List all Parents/Guardians and Siblings

Name	Gender	Relationship to Patient	Age	Live in Home /Pt?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What extra curricular activities is the patient involved in? (Sports, etc.) _____

What does the patient do for fun/relaxation? _____

What problems is the patient having at:

Home? _____

School? _____

With Friends? _____

Has the Child/Adolescent had any suicidal thoughts or gestures ever? _____

Has the Child/Adolescent ever threatened to harm themselves or someone else ever? _____

Has the Child/Adolescent ever been or are they currently incarcerated? _____

Were there any developmental problems at birth or in the first year? If so, please explain: _____

Problems with

Sleep _____

Eating: _____

Toilet Training: _____

Substance Use: _____

Other: _____

Is there any History of Abuse? If yes, when and what kind? _____

Has there ever been placement outside the home? If yes, when and where? _____

Is DSH currently involved or have they ever been involved? If yes, when? Please give name and phone # of DHS Caseworker. _____

List all Previous Inpatient Psychiatric Admissions

Name of Hospital	Date Hospitalized	Reason for Hospitalization	Did it Help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS THERAPY

Name of Therapist	Location of Therapist?	Dates of Therapy	Did it Help?
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT THERAPY

Name of Therapist	Address of Therapist?	Phone # of Therapist	How Often?
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

List all Medical Problems: _____

List all surgeries (including approximate date or age of patient at that time): _____

List all allergies to medication: _____

Other Allergies: _____

CURRENT MEDICATIONS:

Name of Medication	Dose	Date 1 st Prescribed?	Prescribing Practitioner	Problems/ Side Effects?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PAST MEDICATIONS:

Name of Medication	Dose	Date 1 st Prescribed?	Prescribing Practitioner	Problems/ Side Effects?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- Asked Parent/Guardian if they had questions/concerns about upcoming visit.
- Any outstanding questions/issues that need attention: _____

- Informed Parent/Guardian when and who to call if they could not come to the appointment.
- Informed Parent/Guardian that they should arrive at least 30 minutes prior to appointment time for paperwork.
- Informed Parent/Guardian that if they were late, it would take away from their appointment time.

Signature: _____

Date: _____