

Form A. Consent to the Provision of Psychiatric Consultation Via Interactive Video Link

1. I have received and read the information sheet which describes the interactive video link and I understand the process.
2. I consent to provision of psychiatric consultation via an interactive video link connecting DeKalb Youth Service Center (name of agency or clinic) and a psychiatrist or mental health professional from the CCHS/UASOM Telepsychiatry Program.
3. I consent to the release by DeKalb Youth Service Center (name of agency or clinic) to the CCHS/UASOM Telepsychiatry Program of any relevant records or information required by the mental health professional for the purpose of conducting the consultation. I understand that the purpose of sharing this information is to provide background information about the problems I am experiencing and the work that has been done to date in order to facilitate the consultation.
4. I agree to having the results of this consultation shared with my family physician, name of physician, and DeKalb Youth Service Center (name of agency or clinic) in order to keep them informed about the psychiatric diagnosis and treatment.
5. I am aware that information collected from this consultation will be entered into a database that will be used for education, statistics, quality improvement, and other purposes permitted or required by law. Information collected in this way will be pooled with other similar information and neither I nor anyone participating in this consultation will be individually or specifically identified. If research is proposed using the database storage of personal health information, review and approval by the Research Ethics Board will be required beforehand.
6. I understand that I may revoke this consent in writing at any time.

Client Name: _____
(Please print)

DOB: _____
mm/dd/yyyy

Signed: _____
Client's Signature

Date: _____

AND/OR: _____
Parent/Guardian's Signature

Date: _____

Expiration Date (Maximum of 1 year)

CCHS/UASOM TELEPSYCHIATRY PROGRAM

CC# _____

Form B. Consent to Disclose Personal Health Information Pursuant to the HIPAA Health Insurance Portability Act, 1996

I, _____, authorize _____ UA School of Medicine _____
(Print your name) (Hub name/CCHS/UASOM Telepsychiatry Program)

To disclose my personal health information consisting of:

Refer for Telepsychiatry Evaluation

(Describe the personal health information being disclosed)

Or

The personal health information of _____
(name of the person for whom you are the substitute decision-maker*)

Consisting of: _____

(Describe the personal health information to be disclosed)

to _____ (Mental Health Agency)
Other (Specify)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Signature: _____ Date: _____

Otis Washington, LICSW

Witness Name: _____ Organization: _____ DYSC _____ Phone: 256-638-8821 _____

Signature: _____ Date: _____

Expiration Date (Maximum 1 Year): _____

**Please note: A substitute decision-maker is a person authorized by HIPAA to consent, on behalf of an individual, to disclose personal health information about the individual.*

Form C. Information about your Telepsychiatry Consultation

After discussions with you, your clinician has decided to refer you for telepsychiatry consultation for extra help. This will likely be a one-time only appointment with a psychiatrist and/or other mental health professional through live interactive videoconferencing technology. That means that you will be talking with a mental health professional through two-way live T.V., connected by a secure line (phone-like line or internet connection) so that nobody else can listen in. Sometimes a "bridge" has to be used, which means another person, a bridge operator who you will not be able to see, makes sure that the connection happens and this person, too, keeps all information private.

Your clinician will always be in the room with you at your end. Also your parents, guardians and other people working with you may be in the room with you at least for some time. The mental health professional will be located in a facility that is attached to a university teaching center and sometimes there will be students in the room with the consulting mental health professional.

During the consultation, the consultant may want to speak with everyone in the room. We do require that someone is always present in the room with you to make sure that you are comfortable and that everybody is safe. The interview should last about 1 to 1.5 hours and you will be asked many questions so that the consultant can get to know you and your situation as best possible. At the end of that time the consultant will share his/her thoughts on what might be happening with you and might make some recommendation on what might be helpful for you. It is up to you with your family, case workers, and physician on how to use these recommendations.

After the session the consultant will prepare a report which will go at least to your clinician and possibly to your family, doctor/pediatrician. If you want the report to go to anybody else then you and/or your parents/guardian will have to sign a form allowing that to happen. If anything comes up that makes the consultant concerned about you harming yourself or somebody else or that you yourself are at risk of being harmed or abused then the consultant will work with your clinician to do whatever is necessary to make sure that everybody is kept safe.

We realize that sometimes it is not enough to meet with a psychiatrist or other mental health professional just one time and if other meetings need to happen they will be arranged through your clinician. If any medications are recommended they will be prescribed by your own doctor as the consultant psychiatrists will not be your ongoing doctor.

We hope that you will be comfortable talking with the psychiatrist and/or other mental health professional through videoconference and if you have any worries about it, please discuss these with your clinician beforehand and/or with the mental health professional during the consultation. If you have any comments that would help us with this process we are very interested in hearing about those too.

CCHS/UASOM TELEPSYCHIATRY PROGRAM

CC# _____

Form D. Referral Sheet

All areas must be filled out completely before referral is processed.

REFERRAL INFORMATION

Date: _____ Agency: DeKalb Youth Service Center Location: Rainsville, AL

First Consultation or Re-Assessment (if the date of original consultation is 1 year or more prior to this request)

Site Telephone Number: (256) 638-8821 Fax: (256) 638-1854

Person making referral: _____ Agency: _____

E-mail address: _____

Case Manager: _____ Agency: _____

Primary Care Physician: _____ Telephone Number: () _____

Address: _____ City: _____ Zip Code: _____

PATIENT INFORMATION

Patient's Full Name: _____

Male Female DOB (mm/dd/yyyy): _____ Patient's Age: _____ Social Security #: _____

Insurance Provider: _____ ID or Contract #: _____ Group #: _____

Address: _____

City: _____ Zip Code: _____ Contact Phone Number: _____

School Grade: _____ Regular Class Special Education Day Treatment Section 23 Class Not Attending

Language Spoken by Patient: English Spanish Other (specify) _____

Language Spoken by Parents: English Spanish Other (specify) _____

Armed Forces (Patient or Parents): Yes, No Please specify: _____

Currently before the courts: Yes, No Please specify: _____

Please list the complete names of individuals the patient resides with, as well as their relationship to the client (e.g., biological parent, step-parent, adoptive parent, grandparent, sibling): _____

Other (Please Specify): _____

Patient's Residence: Foster Home Group Home / Short-Term Long-Term Detention Care
Secure Setting Open Custody Setting Custody/Detention Care Setting

CCHS/UASOM TELEPSYCHIATRY PROGRAM

CC# _____

Treatment Program: No Yes (please Specify): _____

CCHS/UASOM TELEPSYCHIATRY PROGRAM

CC# _____

Reason for Referral: Full Consultation Diagnosis Medication Management Other: _____

Questions to be answered from this consultation (please be specific): _____

Major Concerns (circle all that apply):

Developmental Delay: _____

FAE/FAS: _____

Socialization Problems: _____

School Problems: Academic Behavioral Truancy Other (please specify): _____

ADHD: _____

Oppositional, defiant: _____

Aggressive Behavior Verbal Physical Other (please specify): _____

Antisocial Behavior Substance Abuse Alcohol Drug Fire setting Other (please specify): _____

Conflict with the law (please specify): _____

Sexual Acting Out Current Past (please specify): _____

Mood Problems Depression Mood Swings Elevated Mood: _____

Suicidal Behaviors Current Past (please specify): _____

Self-Harm: Type (please specify): _____

Anxiety Obsessions Compulsions Worry Avoidant Behavior: _____

Somatization: _____

Eating Disorder: _____

Sleep Problems (please specify): _____

Family Conflict Separation from Parents/Family Grief: _____

Strange, Bizarre Behavior Hallucinations Delusions: _____

Witnessed Traumatic Events Physical Emotional Sexual: _____

Experienced Trauma (please specify): _____

Psychosis: _____

Parent(s)/Guardian(s)' Concerns (please specify): _____

Medical Problems (please specify): _____

Family History of Mental Illness (please specify): _____

CCHS/UASOM TELEPSYCHIATRY PROGRAM

CC# _____

Current Interventions:

None No Previous Agency Involvement

Counseling: Individual Family Parent Group Other: (please specify) _____

1. Involvement in Specialized Program: (please specify) _____

2. Had Previous Mental Health Consultation E.g. Psychologist, other therapist, (Not Telepsychiatry)

No Yes Date _____ By Whom: _____
Mm/dd/yyyy

3. Are there any mental health assessments/interventions pending? (please specify) _____

4. Is this patient currently involved with any other Mental Health Agency, Psychiatrist or mental health professional (please specify)? _____

5. Current Medications

Stimulant (e.g. Ritalin)	Dosage _____	Prescribed	By: _____
SSRI or other Anti-Depressant	Dosage _____	Prescribed	By: _____
Mood Stabilizer	Dosage _____	Prescribed	By: _____
Anti-Psychotic	Dosage _____	Prescribed	By: _____
Anti-Anxiety (Benzodiazepines)	Dosage _____	Prescribed	By: _____
Other Meds (e.g. Insulin)	Dosage _____	Prescribed	By: _____

Information that is mandatory for referral to proceed:

2 consent forms
signed Videoconference Information
Case Summary/Assessment

Information provided for consultation (if available):

Reports: Education Assessment
Drug and Alcohol Assessment
Psychological Assessment
Speech and Language Assessment
Fire Setting Assessment
School
Relevant Medical Information
Social History
Previous Psychiatric Consultations or other Consultations
Service Plan or Case Notes

Youth Justice Court Documents (please specify): _____

Other Behavioral Checklists: _____