**New Admission Packet**

**REVOCATION SECTION**

I do hereby request that this authorization to disclose health information of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Name of Client)*

signed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Enter Name of Person Who Signed Authorization)(Enter Date of Signature)*

be rescinded, effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that any action taken on this authorization prior to

*(Date)*

The rescinded date is legal and binding.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| *(Signature of Client)* |  | *(Date)* |  | *(Signature of Witness)* |  | *(Date)* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *(Signature of Personal Representative)* |  | *(Date)* |  | *(Personal Representative Relationship/Authority)* |

#### VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Name of Client or Personal Representative)*

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The client or his personal representative has been informed that any

*(Date)*

Action taken on this authorization prior to the rescinded date is legal and binding.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| *(Signature of Staff)* |  | *(Date)* |  | *(Signature of Witness)* |  | *(Date)* |

**CONSENT FOR RELEASE OFCONSUMER INFORMATION**

|  |  |
| --- | --- |
| I, the above named hereby authorize |  |

(Name of Center/Program to Release Information)

|  |  |
| --- | --- |
| to release specified information to | **Diligent Care, Inc.** |

(Name of Person/Agency to Receive Information)

|  |  |
| --- | --- |
| and in addition authorize | **Diligent Care, Inc.** |

(Name of Center/Program to Release Information)

|  |  |
| --- | --- |
| to release specified information to |  |

(Name of Person/Agency to Receive Information)

This information shall include only the nature and to the extent which is specified below:

Reason for Referral/Admission

Assessments/Testing – Educational/IQ, Vocational, Speech, Hearing, Vision,

Psychological, Psycho-Social, etc. Affecting CURRENT level of Functioning

CURRENT Medications, if applicable

School Academic Achievement and Behavior Concerns

Other Information

I understand the contents to be released, the need for the information, and that there are state and federal regulations protecting the confidentiality of authorized information, and that it cannot be released without my written consent unless otherwise provided for in the regulations. I hereby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. Any revocation of consent must be in writing.

\_\_

Client Signature Guardian/Legally Responsible Person

Diligent Care, Inc. Representative Date of Consent

# FACE SHEET IDENTIFICATION PAGE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CLIENT NAME | |  | |  |  |
|  | | First | | Middle | Last |
| ADDRESS: |  | | | | |
|  |  | | | | |
| COUNTY OF RESIDENCE: | | |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MALE |  | FEMALE |  | RACE |  |

|  |  |  |  |
| --- | --- | --- | --- |
| HOME PHONE: |  | OTHER PHONE: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MARITAL STATUS: |  | DATE OF BIRTH: |  | AGE: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| CLIENT #: |  | SOCIAL SECURITY: |  |
| MEDICAID: |  | MEDICARE: |  |

|  |  |  |
| --- | --- | --- |
| DIAGNOSIS: | AXIS I |  |
|  | AXIS II |  |
|  | AXIS III |  |
|  | AXIS IV |  |
|  | AXIS V |  |
|  | Allergies: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| PHYSICIAN: |  | PHONE: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AMBULANCE: |  | | PHONE: |  |
| FIRE DEPT: |  | | PHONE: |  |
| POISONCONTROLCENTER: | |  | | |

|  |  |
| --- | --- |
| IN CASE OF EMERGENCY, NOTIFY |  |
|  | |

|  |  |
| --- | --- |
|  |  |
| PARENT/GUARDIAN/OTHER CONTACT | RELATIONSHIP |

|  |  |  |  |
| --- | --- | --- | --- |
| ADDRESS |  | PHONE |  |
| LEGAL STATUS | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| DATE OF ADMISSION |  | DATE FORM COMPLETED |  |

**MEDICAL TREATMENT AGREEMENT**

As the parent/guardian of the above-named resident of Diligent Care, Inc., I grant Diligent Care, Inc. the right to seek and obtain medical treatment on an as needed basis from the following:

|  |
| --- |
|  |
|  |

I understand that this permission is granted for a period of one (1) year from this date, and that I may withdraw this permission at any time I so choose by submitting a written document stating my desire to withdraw said permission to the office of Diligent Care, Inc.

Date

Parent/Legal Guardian Signature

Diligent Care, Inc. Representative

**MEDICATION AUTHORIZATION**

|  |  |
| --- | --- |
| The below mentioned medication has been prescribed for |  |

|  |  |
| --- | --- |
|  | by his/her physician. |

Medication:

|  |
| --- |
|  |
|  |
|  |
|  |

You may request additional information about this medication and its side effects through the QP, RN, or Personal MD.

I, , give permission for certified staff of Diligent Care, Inc., to administer the above mentioned prescribed medication for treatment purposes. I have been notified of the possible adverse side effects that could occur.

I, , will self-administer medication, therefore, there are no prescriptions written and there is no medication administration record in the client file.

I hereby acknowledge that this consent will expire automatically after 365 days from the date on which it is signed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Client Signature or Signature of Parent/Guardian/or Date of Consent

Legal Responsible Person

**MEDICATION IDENTIFICATIONFORM**

The client has been prescribed the medication listed below. This form is used for staff training purposes only.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Medication** | **Init.** |  | **Date** | **Medication** | **Init.** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

The QP will update this form, as needed, if the client has a change in medication.

QP Signature Date

QP Signature Date

QP Signature Date

**SELF-ADMINISTRATION**

**OF MEDICATION AGREEMENT**

(This form is used for adult consumers over the age of 18 that have demonstrated the ability and willingness to self-administer. It can also be used for consumers under 18who require medications that: **1**.can be more effectively self-administered and only monitored by staff, **2.** create an uncomfortable situation for the consumer, and**3.**can more effectively be used or applied by the consumer. Some examples of these medications include topicals, enemas, and some injections.)

I, , (Guardian or legally responsible people) give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Consumer)

permission to self-administer the following medication(s).

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Add an additional Sheet of paper in needed)

Diligent Care, Inc. will not administer these medications (unless requested by the consumer) to the aforementioned consumer, yet will be available to assist with reading prescriptions/directions as prescribed by the physician.

I hereby acknowledge that this consent will expire automatically after 365 days from the date on which it is signed.

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer or Legally Responsible Person

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diligent Care, Inc. Representative or Physician/Psychiatrist Signature

Date of Consent

**CONSENT TO PHOTOGRAH, RECORD AND FILM**

THIS FORM IS TO BE COMPLETED PRIOR TO ANY RECORDING, PHOTOGRAPHING AND/OR FILMING.

I hereby give Diligent Care, Inc hereafter referred to as Diligent Care, Inc., my consent to photograph, record, and/or film

(consumer name)

(Parent/Legal Guardian/Correspondent)

This material may be used for the purpose of:

Training and Education\*

Public Information

Other

I understand that the materials produced are the exclusive property of Diligent Care, Inc. and I hereby relinquish all rights, title, and interest therein and give Diligent Care, Inc. my consent to retain, reproduce, and use the materials as authorized above in the future, except for the following exclusions or limitations:

This consent is subject to revocation by undersigned at any time except to the extent that action has been taken in reliance thereon.

\_\_\_\_\_\_

Client Date

Legally Responsible Person Date

Relationship to Consumer Date

\_\_\_\_\_\_\_\_\_\_\_\_

Diligent Care, Inc. Representative Date

\*Including, but not limited to, new employee training, in-service training and continuing education for staff, programs for interns and trainees in the health care field, workshop and seminars on health care. No further filming will occur at termination of services/placement.

**PERSONAL FUNDS USE**

Consumers of Diligent Care, Inc. hereafter referred to as Diligent Care, Inc. will be required to use their personal funds for the following:

1. Pocket money for outings
2. Clothing, accessories and personal equipment (i.e., private radio, TV, etc.)
3. Any beauty and/or barber shop trip over $10.00
4. Money needed for school/educational outings
5. Personal video tapes, cassette tapes, or magazines for the resident’s enjoyment.
6. Dry cleaning of clothing items.
7. Premiums for personal insurance policies.
8. Fees for camps, vacations, etc.

I have reviewed the above list and understand \_\_\_\_\_\_\_\_\_\_\_\_\_

(Consumer name)

personal funds will be used toward this end.

Parent/Legal Guardian Date

**INSURANCE INFORMATION**

List Insurance(s) that cover this consumer:

1.

|  |  |
| --- | --- |
| Address: |  |
|  |  |
| Policy Holder: |  |
|  |  |
| Insurance# |  |

2.

|  |  |
| --- | --- |
| Address: |  |
|  |  |
| Policy Holder: |  |
|  |  |
| Insurance# |  |

3.

|  |  |
| --- | --- |
| Address: |  |
|  |  |
| Policy Holder: |  |
|  |  |
| Insurance# |  |

4.

|  |  |
| --- | --- |
| Address: |  |
|  |  |
| Policy Holder: |  |
|  |  |
| Insurance# |  |

**CLIENT FEES**

As a Provider of residential and periodic services, State and Federal regulations bind Diligent Care, Inc. in the area of client fees.

As a consumer or Parent / Legal Guardian of a consumer who is served by Diligent Care, Inc. you may expect the following in relation to client fees:

* Most of our clients are eligible for Medicaid funding services. In these cases, there shall be no fees charged for services allowed and reimbursed by Medicaid.
* In those rare cases of a private-pay consumer, the person legally responsible for the client will be billed monthly, in arrears, for services provided.
* The private-pay daily rate for services will be equal to the Medicaid daily rate for the service provided, i.e., residential or periodic.
* Those personal items and services not covered in the Medicaid daily rate include such items as toothpaste, cosmetics, hair care products, haircuts, etc. These items are generally covered by SSI. It may be necessary to bill the consumer or person legally responsible person for the consumer for these items if sufficient SSI funds are not available.

If you have any questions about these issues, please contact the supervising QP for this case.

Parent/Legal Guardian Date

**EXPLANATION OF CLIENT RIGHTS**

Basic Human Rights are assured to each client/consumer served by Diligent Care, Inc. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each client/consumer is assured the right to live as normally as possible while receiving care and age-appropriate treatment.

Each client/consumer has the right to:

* Have an individualized written treatment or habilitation plan setting forth program to maximize the development of her/his capabilities
* Be free from unnecessary or excessive medication. Medication shall not be sued for punishment, discipline, or staff convenience.
* Have medication administered in accordance with accepted medical standards and only upon the order of a physician as documented in the consumer’s record. (Diligent Care, Inc. ) Staff may not measure medication, but assist with self-administration of medication that has been pre-measured by the legally responsible person and left for the provider to give at a specified time. If the client/consumer refuses to take the medication, the (Diligent Care, Inc.), Staff or provider may not force her/him to take the medication.
* Consent to or refuse any treatment offered. Consent may be withdrawn at any time by the person who gave consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible.
* Keep the same right (as age requirement permit) as any other citizen to exercise rights, unless the exercise of a civil right has been disallowed by an adjudication of incompetence, including the right to:

BD21533_dispose of property BD21533_ execute instruments

BD21533_make purchases BD21533_ enter into contracted relationships

BD21533_register and vote BD21533_ bring civil actions

BD21533_marry and get a divorce BD21533_ contact and consult with legal counsel,

BD21533_send and receive sealed mail private physicians, other professionals

BD21533_make/receive confidential and consumer advocates

telephone calls BD21533_ be out of doors daily and have access to

BD21533_make visits and receive visitors physical exercise

BD21533_communicate with individuals BD21533_ participate in religious worship

of his own choice BD21533_ retain a driver’s license as appropriate

BD21533_keep and use personal possessions

BD21533_keep and spend money

My signature below acknowledges that client’s rights have been explained to me. I now have a working knowledge of the information above.

Client Date

Parent/Guardian Date

**CONSENT FOR SERVICE**

|  |  |  |
| --- | --- | --- |
| I, |  | give my consent to |

|  |
| --- |
| Diligent Care, Inc. to provide direct consumer services for |

|  |
| --- |
|  |

Individual/Parent/Guardian:

Diligent Care, Inc. Rep.:

Title:

Date:

**CONSENT FOR TRANSPORTATION**

|  |  |  |
| --- | --- | --- |
| I, |  | give my consent to |

|  |
| --- |
| Diligent Care, Inc. to provide and/or arrange general transportation  services for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Individual/Parent/Guardian:

Diligent Care, Inc. Rep.:

Title:

Date:

**MEDICAL/SURGICAL AGREEMENT**

As the parent/legal guardian of the above-named resident of Diligent Care, Inc. hereafter referred to as Diligent Care, Inc., I hereby grant limited power of attorney to act on behalf of the consumer in case of a medical emergency or condition requiring immediate medical/surgical intervention when attempts to contact the parent/legal guardian have been unsuccessful for the purpose of gaining signed consent for treatment.

Parent/Legal Guardian Signature:

Date:

NORTH CAROLINA

County of

I, , Notary Public, do certify that personally came before me this day and acknowledged that is a consumer of Diligent Care, Inc. and that the facility personnel has the authority to act on behalf of , and willingness agrees to the foregoing stipulation of this agreement.

Witness my hand and notaries seal this day of , 20 .

Notary Public

My Commission expires:

**Screening/Referral Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DSM IV Diagnosis:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Status/Issues:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Educational Status/Needs:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vocational Status/Needs:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Concerns or Problems:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous Placement History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recommendations:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VISITATION REPORT**

Resident’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons who have permission to visit the consumer, at their residence.

|  |
| --- |
|  |
|  |
|  |
|  |

Persons who have permission to visit the consumer, by a pre-arranged meeting or can remove the

consumer from the premises for day visits. These are not to be overnight visits.

|  |
| --- |
|  |
|  |
|  |
|  |

Comments:

|  |
| --- |
|  |
|  |

I understand that Diligent Care, Inc. its personnel and attending physician will NOT be held responsible for any accidents or for any deterioration while the consumer is not at their residence in any of the above-referenced person’s care. I further understand that I can rescind this permit at any time by notifying the supervising QP, the Clinical Director, or the Operations Director in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diligent Care, Inc. Representative Parent / Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

**RESTRICTIVE INTERVENTION CONSENT**

Date:

Our company’s policy requires all staff to complete a restrictive interventions course, as there are times when the behavior of our consumers calls for physical/restrictive intervention by staff, therefore, Diligent Care, Inc. requires consent to use restrictive interventions, if needed, if continuous behaviors exist, namely:

* Consumer is causing or attempting to cause injury to another consumer, staff, or other individual
* Consumer is causing or attempting to cause injury to himself or herself
* Consumer is causing or attempting to cause excessive property damage

Diligent Care, Inc. will not use time outs, isolation, or seclusion. Nor does Diligent Care, Inc. use mechanical devices or medication regimen protocols as a means to control the behaviors of a consumer. Diligent Care, Inc. will only use prescribed medications from a licensed physician, and only for its intended purpose.

I, , hereby give consent for Diligent Care, Inc. to use restrictive interventions, as needed, if the aforementioned conditions exist. I further understand that this consent is valid for six months from the date that it is signed. This consent may be revoked with written notice at any time prior to the six month expiration date.

Signature of Parent/Guardian Date

Signature of Diligent Care, Inc. Representative Date

**PHYSICIAN’S STANDING ORDERS**

**The following orders are good for 1 year from the date signed. Strike through any orders you do not want applied to this consumer. Age and weight have been taken into consideration, and dosages may be administered according to age/weight if different than directions listed below.**

**FOR MILD PAIN or REDUCING FEVER**: Tylenol (Acetaminophen) 650mg or Ibuprofen 200 mg. 2 tables every 4 hours or prn for minor pain/headache 48 hrs (may give tablet, liquid=20 cc or suppository form as patient’s condition indicates). 3 days for mild or minor pain/headache or temperature over 100 degrees. Notify M.D. if temperature is over 102, continued minor pain or headache.

**FOR COUGH**: Robitussin D.M. (Guaifenesin w/Dextromorphan) 10ml/10cc – po Q 4 hrs prn for cough x 48 hrs. Notify M.D. of continued cough. (DO NOT TAKE WITH TYLENOL COLD.)

**FOR COLD SYMPTOMS:** Warm salt water rinse or Chloraseptic Spray for sore throat PRN for 3 days. Throat Lozengel tablets of choice PRN for a maximum of 3 days.

Sudafed 2 tablets (60 mg) by mouth for a maximum of 3 times per day. Give doses of Sudafed at least 6 hours apart for a maximum of 7 days.

**FOR SORE THROAT**: Chloraseptic spray/lozenges – 5 sprays or dissolve 1 lozenge Q 2 hrs prn for sore throat x 48 hrs. Notify M.D. of continued sore throat.

**FOR RUNNY NOSE**: Tylenol Cold Tabs every 6 hrs, not to exceed 8 tabs in 24 hrs. Do not take any Tylenol or any ANSAIDS while on this.

**FOR INDIGESTION**: Mylanta (antacid) susp. – 30ml po Q 4 hrs prn indigestion/stomach upset x 48 hrs. Notify M.D. of continued symptoms.

**FOR CONSTIPATION**: Milk of Magnesia – 30-60 cc orally every day or laxative of choice PRN up to 3 times a day. If no results within 24 hrs, may give Dulcolax (bisacodyl) supp. PR x 1 prn for constipation. If no bowel movement in 24 hrs check for impaction. If impacted, remove impaction. If not impacted, give Fleets Enema PR x 1. If not effective, notify M.D.

**FOR DIARRHEA**: If 3 loose stools in 24 hrs, hold all laxatives and stool softeners. Kaopectate 30 cc po after 1st loose stool, then every 2 hrs prn – no more than 6 doses in 24 hrs or Imodium 1 capsule by mouth every 4 hours PRN. NOTIFY PHYSICIAN IF DIREA IS NOT RELIEVED IN 3 DAYS. .

**FOR NAUSEA OR INDIGESTION**: Pepto-Bismol 30 cc by mouth every 4 hours PRN for 3 doses. Mylanta or Maalox 30 cc by mouth every 4 hours PRN up to 3 doses. Antacid tablets of Choice by mouth or Dramamine (dimenhydrinate) 50mg po Q 4 hrs prn for nausea x 48 hrs. Or Phenergan 25mg supp. Q 4 hrs prn for nausea x 48 hrs. If not effective, notify M.D.

**FOR MINOR ABRASIONS, CUTS BURNS OR SCRATCHES**: Cleanse area with peroxide OR beta dine scrub topically with dressing applied externally PRN and apply Neosporin Ointment (triple antibiotic ointment), to the area externally PRN and then apply non-adhering dressing PRN or Q day until healed.

**FOR EYE IRRITATION:** Visine, Murine or Artificial tears 2 gtts. In the irritated eye every 4 hours PRN while awake.

**FOR EAR WAX:** Debrox instill 4 -10gtts, 2 times per day in the ear up to 4 days.

**FOR ITCHING:** Benadryl 2 capsules by mouth every 4 hours PRN for up to 4 days. Hydrocortisone Cream ½% apply topical to rash PRN.

**RASH**: Benadryl (diphenhydramine) 25mg bid prn for rash x 24 hrs. Do not overlap with other antihistamine medications. If not resolved in 24 hrs, call M.D.

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_

Signature of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Other Orders / Modifications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*Therapeutic Leave not to exceed 60 days per calendar year.**

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date

**PROVIDER SELECTION FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been provided a list of service providers. My signature below confirms that I have selected my service provided freely, without influence, pressure or coercion, direct or indirect, from my Care Coordinator or any member of my family or treatment team.

I have selected **Diligent Care, Inc.** to be my *(mark all that apply)*

\_\_\_\_\_ Residential Support Services/Supervised Living

\_\_\_\_\_ In-Home Skill Building

\_\_\_\_\_ Day Support

\_\_\_\_\_ Supported Employment

\_\_\_\_\_ Community Guide

\_\_\_\_\_ Developmental Day

\_\_\_\_\_ Respite

\_\_\_\_\_ Other Services Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Consumer Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Diligent Care, Inc. Representative Date

PHYSICIANS/MEDICAL ORDERS

|  |  |  |  |
| --- | --- | --- | --- |
| **CLIENT NAME:** | | **RECORD NUMBER:** | |
| **DATE OF BIRTH:** | | **MEDICAID ID #:** | |
| **\*\* Note to the Physician: Please sign after each entry and list all medications orders.** | | | |
| **DATE** | MEDICATION NAME, STRENGTH,ADMINISTRATION DIRECTIONS, PURPOSE | | **MD/Medical Professional Signature** |
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**01/01/2012 PHYSICIAN’S ORDERS**

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

45 C.F.R, Parts 160 and 164; 42 C.F.R. Part 2; G.S. 122C

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122 C).

**CLIENT’S NAME: \_\_\_\_\_\_ RECORD NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_ \_ SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_Diligent Care, Inc\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of client or client’s legally responsible person Agency or person authorized to use and disclose the information*

to use or disclose to/with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_

*Name of agency or person to whom the requested use or disclosure will be made (include address, if applicable)*

**THIS DATA SHALL INCLUDE (***client is encouraged to initial beside data to be used or disclosed)*

\_\_\_\_Assessments \_\_\_\_Service Notes \_\_\_\_Substance Abuse/Treatment

\_\_\_\_Psychiatric Evaluations \_\_\_\_Service Plans/Goals \_\_\_\_HIV/AIDS Information

\_\_\_\_Psychological Evaluations \_\_\_\_Discharge Summary \_\_\_\_Social, Developmental, Medical History

\_\_\_\_Diagnoses \_\_\_\_Financial/Reimbursement

\_\_\_\_Other:

**PURPOSE OF USE OR DISCLOSURE** *(client is encouraged to initial beside data to be used or disclosed)*

\_\_\_\_At the request of the individual \_\_\_\_Assessment/Evaluation \_\_\_\_Coordination of Service

\_\_\_\_Court Proceedings \_\_\_\_Determination of Benefits

Information requested should be mailed to this address: Diligent Care, Inc. 320 Magnolia Square Ct. Aberdeen, NC 28315\_\_

**REDISCLOSURE**

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

**REVOCATION AND EXPIRATION**

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Notice of Privacy Practices, a copy of which has been given to me. If not revoked earlier, this consent shall be valid until cessation of financial benefits.

**NOTICE OF VOLUNTARINESS**

I understand that I may refuse to sign this authorization form. I understand that Diligent Care will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

***Date of expiration, if less than one year Event, if less than one year***

Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

Signature of legally responsible person, if required Date

Please explain LRP authority to act on behalf of the client:

Power of Attorney GuardianStaff Signature

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Verification of Consumer Choice

I have received information regarding services which I am eligible to receive along with service providers from whom I am eligible to receive such services. Based upon this information, I have made an informed choice of my services and provider(s) to be provided by Diligent Care, Inc. I have selected Diligent Care Inc. as my provider of the services checked below.

**My choice of service provided by Diligent Care, Inc. at**

**320 Magnolia Square Ct. Aberdeen, NC 28315 are as checked below:**

Community Guide

IDD Services

Day Services

Residential Services

In-Home Skill Building

Personal Care Services

Day Support Services

Respite Services

ADVP Services

Intensive In Home Service

Residential Support Services

Supervised Living

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Consumer/Legally Responsible Person Date:

**\*Telephone request by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Member Date:

**\*Consumer/Legally Responsible Person unavailable to Sign**

May/06 Verification of Consumer Choice