Outer Cape Health Services
Psychiatry Registration

FIRST (GIVEN) NAME _____ LAST (FAMILY) NAME _____ **DOB:** _____ MM/DD/YYYY

Instructions:
Please be sure to complete all parts of the registration packet **prior to your first appointment** with OCHS Psychiatry, including:

- **Psychiatry No Show and Cancellation Policy**
- **Behavioral Health Sharing Information Authorization**
  Please fill out for your **therapist** if outside of Outer Cape Health Services
- **Authorization for Request of Protected Health Information**
  For **ALL** past outpatient psychiatry and inpatient psychiatric hospitalizations

Completed forms may be faxed to (508) 487-6298**,** emailed to **ochsrecords@outercape.org** or dropped off at Outer Cape Health Services.

Please note: If you email a form(s) to Outer Cape Health Services, it will not be encrypted, and therefore not secure. If you have any questions, you may contact the Compliance Department at (508) 905-2800.

REASON FOR SEEKING TREATMENT

What is going on right now? Briefly describe your reason for seeking treatment at this time

_____

_____

Briefly describe your past Psychiatric/Mental Health History

_____

_____

_____

MENTAL HEALTH TREATMENT

Please note any mental health or substance abuse treatment you are **currently** receiving (Counseling/therapy, MAT)

TYPE	DATES	NAME/LOCATION

Have you been in psychiatry (mental health medication management) previously? _____

If yes, please indicate approximate dates of treatment, reason for treatment, and provider's name:
Please complete record release for each (Authorization for Request of Protected Health Information)

PSYCHIATRIC PRESCRIBER	REASON AND/OR DATES

Describe any hospitalizations (mental health or substance use). Give approximate dates and reason for treatment:
Please complete record release for each (Authorization for Request of Protected Health Information)

DATE/LOCATION	REASON FOR HOSPITALIZATION

CURRENT MEDICATIONS (PSYCHIATRIC AND OTHER)

MEDICATION NAME	DOSE	FREQUENCY	DATE STARTED

Are you concerned about the amount of alcohol you drink?	◯ YES	◯ NO
Have family or friends ever expressed concern about your drinking?	◯ YES	◯ NO
Do you smoke/vape?	◯ YES	◯ NO
Have you ever used recreational or street drugs?	◯ YES	◯ NO
Have you ever misused prescription or non-prescription drugs?	◯ YES	◯ NO
Have you ever given yourself drugs (other than prescribed) using a needle?	◯ YES	◯ NO
Do you use cannabis?	◯ YES	◯ NO

I certify that the above information is true and correct.

CLIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE)	DATE	NAME OF AUTHORIZED REPRESENTATIVE (IF CLIENT UNABLE TO SIGN)	RELATION TO CLIENT (IF CLIENT UNABLE TO SIGN)

COMPLETE ONLY FOR TREATMENT OF CHILDREN (<18 Years Old)

Describe any difficulties during pregnancy, labor or delivery include medications and substance/alcohol use during pregnancy.

_____

_____

_____

Describe any developmental delays or significant past medical problems_____

_____

_____

_____

Child lives with: ☐ Mother (biologic) ☐ Father (biologic) ☐ Stepmother ☐ Stepfather

☐ Foster Parent ☐ Grandparent (s) ☐ _____

In case of divorce/separation, who has legal custody: ☐ Mother ☐ Father ☐ Joint ☐ _____

Please describe any visitation arrangements: _____

_____

Describe any DCF or other agency involvement: _____

_____

I certify that the above information is true and correct

CLIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE)	DATE	NAME OF AUTHORIZED REPRESENTATIVE (IF CLIENT UNABLE TO SIGN)	RELATION TO CLIENT (IF CLIENT UNABLE TO SIGN)
_____	_____	_____	_____

NOTE: Parents need to be available to consent for every treatment (in-person and telehealth). Minors must also agree to treatment.

OUTER CAPE HEALTH SERVICES
PSYCHIATRY
NO-SHOW and CANCELLATION POLICY

1. To schedule an initial intake appointment, Outer Cape Health Services (OCHS) will reach out to patient by telephone up to three times. If the patient does not return the phone call directly, then OCHS will send a letter asking the patient to call to schedule their initial intake. If the patient does not call to schedule within 10 days of the letter being sent, their case will be closed. Patients are invited to start re-establishment process if desired.
2. Patients who no-show one intake appointment will have the opportunity to call to reschedule one time. A letter will be sent to the patient after a No-Show to the initial intake appointment informing the patient that their referral will be closed if Outer Cape Health does not receive a phone call to reschedule within 10 days of letter sent.
3. Once established with psychiatric provider, after three attempts to engage patients in psychiatry services for follow-up appointments, patients will be notified via letter of discharge from psychiatry services at Outer Cape Health Services. Patients are invited to start re-establishment process if desired.

I certify that I have read and have received a copy of the Psychiatry No-show and Cancellation Policy.

CLIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE)	DATE	NAME OF AUTHORIZED REPRESENTATIVE (IF CLIENT UNABLE TO SIGN)	RELATION TO CLIENT (IF CLIENT UNABLE TO SIGN)

Psychiatry Confidentiality Agreement

Generally speaking, communications between a patient and mental health provider are confidential and may not be disclosed without your consent, or as otherwise provided by law. There are exceptions to the general rule of confidentiality which would require that the mental health provider report his or her concerns without the consent of the patient.

These occasions include, but are not limited to the following:

- Suspected child abuse or dependent adult abuse or elder abuse for which mental health providers are required by law to report to appropriate authorities immediately
- If is patient is threatening serious bodily harm to another person, the mental health provider is required by law to report to appropriate authorities immediately
- If a person intends to harm him/herself, the mental health providers will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, the mental health provider will take further actions, permitted by law, to ensure their safety.

In addition, if you make your mental health a point of litigation you implicitly waive the right to confidentiality and your physician/therapist may be compelled to release your records, give a deposition, and/or testify in court.

Regarding minors, children and adolescents (<18 years old) seen in individual session are entitled to confidentiality, except under certain circumstances. However, parents have the right to view their child's treatment records. Therefore, it is helpful to work out an arrangement ahead of time so that the child feels their privacy is respected, while at the same time, parent have access to critical information. A typical arrangement is that unless a child has been abused or is a clear danger to self or others, the psychiatrist will only disclose the following (unless given consent by child):

- Whether sessions are attended
- Whether child is generally participating or not
- Whether progress is generally being made.

I certify I have read and agree to the Psychiatry Confidentiality Agreement.

CLIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE)	DATE	NAME OF AUTHORIZED REPRESENTATIVE (IF CLIENT UNABLE TO SIGN)	RELATION TO CLIENT (IF CLIENT UNABLE TO SIGN)

Outer Cape Health Services – Controlled Substance Agreement

Note: This is NOT a guarantee you will be prescribed controlled substances. If you are prescribed controlled substances, these are the expectations and responsibilities.

Clinician Responsibilities

- To make sure this medicine is helping and not hurting you.
- To NOT continue medicines prescribed by others unless they are safe and are the best treatment for your problem.
- To routinely check the state Prescription Monitoring Program website to see the controlled substances that you are getting from me and others.
- To have your refills prescribed when they are due.
- To work with other specialists to make sure you are getting the best treatment possible.
- To provide care for you whether or not you are getting this medicine.
- To refer you for addiction treatment if you become addicted to this medicine.
- To only prescribe stimulant medications using FDA-approved dosages and indications.

Patient Responsibilities

- I will follow the treatment plan, including keeping all appointments set up by my clinician. High-risk patients are required to have a visit with the prescribing clinician every 3 months, standard risk patients every 6 months. Medication will be stopped in a safe way if an additional 3 months pass without a visit with the prescribing clinician for either risk group.
- I am responsible for my medicines. I will not share, sell or trade my medicine. Doing so is a crime according to the Federal Controlled Substance Act.
- My prescription will only be filled at the pharmacy indicated above unless discussed with my prescribing clinician or a member of my clinical team. Prescriptions will not be electronically prescribed to pharmacies outside of Massachusetts.
- I will keep my medicine in a safe place where no one else will be able to take them, locked-up if possible. They could be very dangerous to others, especially children.
- I will not take anyone else's medicine.
- I will take my medications exactly as prescribed, and not take extra doses. I understand that my medicine will not be replaced if it is lost, stolen, damaged or used up sooner than prescribed.
- I will dispose of the medicine using proper methods – such as bringing it to a secure take-back location; for example, a police station that offers this service.
- I will come in for a pill count and urine drug test anytime I am asked to do so within 48 hours of request, even if I don't have a clinic appointment on that day.
- I agree to give a urine sample for drug testing on the day it is requested whenever I am asked.
- I will not use any street or illegal drugs. I will not use any medications that have not been prescribed for me.
- I understand that use of this medicine is only one part of treatment plan. My clinician will continue this medicine only if the medicine is helping and not hurting me.
- I will treat all people working at Outer Cape Health Services with respect whether in-person, on the telephone, or on-line.

- If I am prescribed another medication, including controlled substances, from a clinician outside OCHS, I will notify my clinician or nurse the next time I am in clinic. I will bring this medicine to my next visit in the original bottle even if the bottle is empty.
- I will maintain an active telephone with a voicemail at all times so that the Outer Cape Health Services staff can reach me.

Refills
- Refills must be requested no later than 2 regular business days prior to the refill date (Monday through Friday, holidays excluded) during normal business hours.
- No refills for this medicine may be requested from the answering service on nights, holidays or weekends. The on-call clinician will not provide refills.
- No early or emergency refills may be made.

Privacy
- While I am taking this medicine, my clinician may need to contact other clinicians or family members to get information about my care and use of this medicine. You will be notified to provide consent.

Stopping the Medication
- If I do not follow this agreement, or if my clinician decides that this medicine is hurting me more than helping me, this medicine will be stopped in a safe way.

Informed Consent Regarding Risks
- I have been told about the possible risks and benefits of this medicine. The medicine may help my problem but may cause other problems like addiction, overdose, and death.
- The most common adverse reactions are loss of appetite, upset stomach, loss of sleep, and headaches. Increases in heart rate and blood pressure are possible. Patient with pre-existing heart conditions should not use stimulant medications.
- Other rare adverse reactions include decrease blood flow to fingers and toes as well frequent or painful erections (priapism). Muscle breakdown (rhabdomyolysis) is also possible. Additionally, some patients will experience increases in hearing voices, psychosis, or mania. Increases in irritability, anger, and anxiety are also possible.
- I may get addicted to this medicine. This could cause me to get into trouble and have problems at home or work. If I or anyone in my family has a history of drug or alcohol problems, I will have a higher chance of addiction to this medicine.

I certify that I have read and agree with the Controlled Substance Agreement.

CLIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE)	DATE	NAME OF AUTHORIZED REPRESENTATIVE (IF CLIENT UNABLE TO SIGN)	RELATION TO CLIENT (IF CLIENT UNABLE TO SIGN)

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name _____ Age _____ ❑ Male ❑ Female Date _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ Hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None**	**Slight** Rare	**Mild** Several days	**Moderate** Half or more	**Severe** every day	**Highest Domain Score** clinician
I	I. 1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

DSM-5-TR Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age: ____** **Date:_____**

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Outer Cape
HEALTH SERVICES

Behavioral Health Sharing Information Authorization

Patient Name: _____Patient Date of Birth: _____Phone Number:_____

Patient Address: _____
Street City/Town State Zip Code

I authorize Outer Cape Health Services to disclose to and/or obtain from:

Person/Agency: _____ Phone: _____ Fax:_____

Person/Agency Address: _____
Street City/Town State Zip Code

(Patient/Client should initial each item to be disclosed)

_____Assessment
_____Diagnosis
_____Psychosocial Evaluation
_____Progress in Treatment
_____Presence/Participation in Treatment
_____Behavioral Health Progress notes

____ Discharge/Transfer Summary
____ Educational Information
____ Psychological Evaluation
____ Medication Management
____ Nursing/Medical Information
____Other

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services

Release of information must comply with the federal HIPAA Privacy Act and federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations. Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

I hereby disclose my health information for the purposed noted above. I understand that once such information has been disclosed to the intended recipient, that OCHS cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. If I have questions about disclosure of my health information, I can contact the Outer Cape Health Services Compliance Officer: 508-905-2820 or patientexperience@outercape.org

This authorization is valid for release of Protected Health Information for 180 days from date below **OR (**please indicate):
❑ a one-time disclosure ❑ upon termination from services ❑ until revoked in writing ❑ other

_____
Signature of Patient or Parent/Guardian Relation to Patient Date

_____
Signature of Staff Witness Date

A facsimile copy of this document is valid as the original. Revised 11.02.2022

Scan Completed Document to EMR: Consents and Contracts

Authorization for Request of Protected Health Information

Outer Cape HEALTH SERVICES

Patient Name Last	First	Middle Initial	**Patient Date of Birth** (mm/dd/yyyy)

Patient Address Street	City/Town	State	Zip Code

Patient Phone Number

I hereby authorize and request a copy of my medical records be sent by mail or fax to:

Outer Cape Health Services
P.O. Box 598, Harwich Port, MA 02646
Fax: 508-487-6298

For the purpose of: ☐ Personal ☐ Legal ☐ Transferring Care ☐ Other

Requested Information: _____ ☐ All Records

Covering the period from: _____ to _____

Former Practice Information

_____
Practice Name

_____
Practice Address

_____
Phone Number Fax Number

Protected under State Law: Please initial below	
Alcohol and/or Drug Abuse Treatment	I DO Authorize. Initial:
HIV/Communicable Disease*	I DO Authorize. Initial:
Genetic Testing	I DO Authorize. Initial:
Mental Health Services	I DO Authorize. Initial:
(Mental Health Services by a clinical nurse specialist, Psychologist, Social Worker, counseling professional or a physician specializing in psychiatry licensed under the provision of Title 32)	

This authorization is valid for release of Protected Health Information for 180 days from date below **OR** (please indicate):

☐ a one-time disclosure ☐ upon termination from services ☐ until revoked in writing ☐ other

Patient or Legal Representative Name (print) _____

Address: _____

Patient or Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____ Phone Number: _____

To the practice sending records, please send **only** the following:

- Health maintenance sheet
- Immunization record
- Last CPE
- Last 3 office visit notes
- Labs for current and previous year
- All pathology reports
- Last PAP report and any abnormal reports
- Last colonoscopy and any abnormal reports
- Last mammogram and any abnormal reports
- Last chest x-ray and any abnormal reports
- All MRI's, CT's, interventional radiology studies
- All consults in the past 2 years with exception, of all cardiology, oncology, neuropsychiatry and pain consults
- All cardiology testing in the last 2 years
- All neurology testing (EMG, EEG) or pulmonary testing in the past 2 years
- Hospital discharge summaries
- All mental health records for the past 2 years

*A separate release authorization is required for each request to release the results of HIV/AIDS testing, M.G. L. c111§ 70F

**Release of information must comply with the federal HIPAA Privacy Act and federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations. Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

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Revised 2/23/2021