Penn Psychiatric Center's

School Based Therapy Program

Fax Cover Sheet and Checklist

Date: ____________________

To:

Penn Psychiatric Center
Fax #: 610-917-2360
Attn: Program Administrator
Re: School Program Referral

From:

School: ____________________

Sender: ____________________

Fax #: ____________________

Please take care to fill out all forms completely.
The information requested is crucial to our ability to provide therapeutic services.

Questions about how to fill out the forms? The Program Administrator is here to help!
Phone: (484) 972-0346
Email: programsupport@ppcmh.com

Included in this Fax:

All of these documents must be included

- ☐ **Referral**
  Completed by Counselor or Social Worker
- ☐ **Informed Consent**
  Completed by parent if student is under 14; by student if 14 or older
- ☐ **Narrative Description**
  Completed by the student's Teacher or Counselor
- ☐ **Student's School Schedule**
  This is crucial to scheduling therapy appointments.

Information contained in this fax is confidential and protected by both Federal and State confidentiality regulations. The information is intended only for the use of the individual or entity to which it is addressed, and contains information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you receive this communication in error, please notify us immediately by telephone at (610) 917-2200 and return the original message to us via first class mail. If you are the intended recipient of this facsimile, please be advised that this information has been disclosed to you from records whose confidentiality is protected by Federal Law (Federal Regulation 42 CFR Part 2). This prohibits you from making any further disclosure without the written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

Penn Psychiatric Center

Referrral Form for Outpatient School-Based Therapy

Student Information:

Last Name: ______________ First Name: ______________ Middle Initial: ______
DOB: ______________ Gender: ______ SSN: ______________ Ethnicity: ______________
Address: ______________ City: ______________ Zip: ______
Primary Insurance: ______________ ID#: ______________
Secondary Insurance: ______________ ID#: ______________

Family Information:

Living Situation: ______________
Primary Family Contact: ______________ Relationship to Student: ______________
Cell Phone : ______________ Home Phone: ______________
Email: ______________

School Information:

Name of School: ______________ Grade: ______
Designated Therapy Room: ______________ Who to Contact to Reserve Room: ______________
Student's School Counselor: ______________
Does this student have an IEP or 504 Plan in place? If so, please explain: ______________
____
Reason for Referral: ______________
____
School Attendance: ☐ Regular ☐ Sporadic
School Performance: ☐ Above Average ☐ Average ☐ Below Average ☐ Failing
School Behavior Problems: ☐ None ☐ Occasional ☐ Constant
From which classes can this student be pulled for therapy?: ______________
____
Is the student aware that they are being referred for therapy? ☐ Yes ☐ No
Is the student's parent or guardian aware that they are being referred for therapy? ☐ Yes ☐ No

Person Submitting Referral (School Counselor or Social Worker):

Name: ______________ Title: ______________ Phone: ______________
Email: ______________ Best Time to Contact: ______________
Signature: ______________ Date: ______________

Please fax completed referral form, checklist, teacher/counselor narrative, and consent for treatment forms to the attention of the Program Administrator: (610) 917-2360

Questions about this form? Call the Program Administrator: (484) 972-0346

Penn Psychiatric Center

Informed Consent for Treatment for Outpatient School-Based Therapy

3774 Ridge Pike
Collegeville, PA 19426
610-486-3333

601 Gay St. Suite 6
Phoenixville, PA 19460
610-917-2200

Client____

I, ____, the undersigned, hereby attest that I have voluntarily given my consent for the treatment of the minor or person under my legal guardianship mentioned above, at **Penn Psychiatric Center, Inc**., hereby referred to as the Center. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or nurse in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating clinician(s). This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights and HIPAA pamphlets and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the HIPAA Privacy Officer.

Non-Voluntary Discharge from Treatment: A client may be terminated from the **Center** non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the **Center** is protected by Federal and/or State law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as a mental health consumer or an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients under the age of 14 have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

Attendance Policy: PPC is dedicated to providing the most effective treatment to all those who seek services. In order to do this it is important for clients to attend all scheduled appointments. Additionally, individuals who demonstrate a pattern of cancelled or missed appointments may no longer be able to receive treatment with the Center.

Payment: I hereby authorize any insurance benefits to be paid directly to the physician and I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim.

I consent to this treatment and agree to abide by the above stated policies and agreements with **Penn Psychiatric Center, Inc**.

____ _______________________

Signature of Client/Legal Guardian Date
(In a case where a client is under 14 years of age, a legally responsible adult acting on his/her behalf)

____ _______________________

Witness Date

Penn Psychiatric Center

School Based Outpatient Program

Narrative Description of Student – Completed by: Teacher/Counselor

Student's Name: ______________________________ Date of Birth: ____________________

Teacher's Name: ______________________________ Date Completed:____________________

Instructions: Please describe what you view as the primary problems associated with this student. In addition, please describe how this student's problems have affected the following areas and circle the appropriate rating in each box. Continue on a separate sheet if necessary.

(1) How this student's problems affect his or her relationship with other student's and in the classroom in general…

Severity of Problem
Please circle:
No Problem (0 1 2 3 4 5 6 7 8 9 10) Extreme Problem

(2) How this student's problems affect his or her relationship with teachers…

Severity of Problem
Please circle:
No Problem (0 1 2 3 4 5 6 7 8 9 10) Extreme Problem

(3) How this student's problems affect his or her academic progress…

Severity of Problem
Please circle:

No Problem (0 1 2 3 4 5 6 7 8 9 10) Extreme Problem

Additional Notes: