PATHFINDER

CHEYENNE COMMUNITY DRUG ABUSE TREATMENT COUNCIL, INC.
ACKNOWLEDGEMENT OF TREATMENT RIGHTS, CONFIDENTIALITY OF CLIENT RECORDS, GRIEVANCE PROCEDURE AND CONSENT TO TREATMENT / EVLAUATION

TREATMENT RIGHTS:
Each client shall have impartial access to treatment regardless of race, religion, sex, sexual orientation, ethnicity, age, and physical handicap, type of mental health or substance abuse disorder, or source of financial support. Each client's personal dignity and privacy shall be recognized and respected in the provision of all care and treatment.

CONFIDENTIALITY OF CLIENT RECORDS:
Records of the identity, problems, treatment and the fact that someone is a consumer of Pathfinder services are confidential and comply with 42 CFR, "Confidentiality of Alcohol and Drug Abuse Treatment Patient Records" and the HIPAA Privacy and Security regulations. The release of any program information may take place only with prior written consent of the client with the following exceptions:

- To medical personnel when necessary to meet a medical emergency,
- If authorized by an appropriate order of the court, granted after showing good cause usually after the program has had the opportunity to give testimony as to why the evidence should not be released. If such an order is granted, the court will ensure appropriate safeguards against disclosing information that is not related to the court order.
- To qualified personnel for the purpose of conducting scientific research, management and financial audits or program evaluation. Such personnel may not identify any individual in any report of such research, audit or evaluation, or otherwise disclose patient identities in any manner.
- To the Wyoming Department of Health, Behavioral Health Division personnel for the purpose of review, audit, certification, payment or complaint investigative processes.
- Pathfinder staff members are obligated by Wyoming law to report any suspicion of child abuse or neglect or any situation where an individual threatens to do physical harm to himself/herself or others. Pathfinders may also disclose information to the extent necessary to defend themselves against a lawsuit initiated by or on behalf of a client. Clients should also be aware that any person who commits a crime on Pathfinder premises can and will be reported to the appropriate authorities.

SECURITY PRECAUTIONS:
Records containing any information pertaining to clients shall be kept in a locked file cabinet, safe or other similar container when not in use. Pathfinder shall maintain client records for a period of seven (7) years from the date of termination or treatment or service, except for minors whose records shall be maintained until such time as the minor attains the age seven (7) years beyond the age of majority.

GRIEVANCE PROCEDURE:
Should any client have a grievance as to how their treatment is being conducted or a specific complaint about the Pathfinder program, the procedure established for resolving grievances should be followed. A copy of this procedure is in the intake packet and a copy will be provided to you. Additional copies can be obtained from your counselor or the front desk.

HIV / AIDS / HEPATITIS / TB / AND SEXUALLY TRANSMITTED INFECTIONS:
You will be provided information, counseling and/or a referral for testing for HIV/AIDS/HEPATITIS/TB as well as information regarding sexually transmitted infections (STI).

CONSENT TO TREAT:
I understand my rights to treatment, confidentiality, security and the grievance procedure as explained above. I voluntarily agree to participate in treatment at Pathfinder.

______________________________________	____________________
Client's signature authorizing evaluation / treatment	Date
______________________________________	____________________
Counselor / Witness	Date
______________________________________	____________________
Parent / Guardian signature authorizing evaluation / treatment	Date

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INTAKE/REQUEST FOR SERVICES
STAFF ONLY

Referral Date: ___________________ Date of Assessment Interview: _________________
Location: ____
Staff Conducting Interview: ____
Referral Source: ____
Reason for Referral (according to referral source: ____________________________________
____
Information provided by the Following: ☐Client ☐Parent(s) ☐ Guardian ☐ Family/Friend
☐Physician ☐Records ☐Law Enforcement ☐Service Provider ☐School Personnel
☐ Other: _______________

Name: ____ Maiden Name: _____________________
Last First M.I.

Address: ____
City State Zip County of Residence

Phone: Home _______________ Cell _______________ Work _______________ Initial-if ok to leave a message ________

Date of Birth: _____/_____/_____ Age: ________ Place of Birth: ________________________________

Gender: ☐ Male ☐ Female ☐ Transgender

Social Security Number: ______________________________

Mother's first name: ______________________

What language do you speak? ☐ English ☐Spanish ☐ Other

What language do you write? ☐ English ☐Spanish ☐ Other

Do you require any accommodations or have any special needs: ☐No ☐Yes

If yes, please explain: ____

Racial Group: (check one)

☐ White	☐ Native Hawaiian
☐ Black	☐ Pacific Islander
☐ Asian	☐ Multi-Racial
☐ Native American	☐ Other
☐ Alaska Native	☐

Ethnicity: (check one)

☐ Hispanic	☐ Puerto Rican
☐ Mexican	☐ Unknown
☐ Cuban	

Are you a U.S. citizen? ☐Yes ☐No

Describe what brings you to Pathfinder: ____

Have you been seen by Pathfinder before? ☐No ☐Yes When? ______________________________

Who referred you to Pathfinder? ____

In Case of Emergency Contact

Name: ___________________________ Relationship to Client: _________________

Cell Phone: ___________ Work Phone: ____________ Home Phone: ______________

Address: ____________________City: _________________State: ________________

BRIEF MEDICAL SCREENING

(Check all that apply to your current health status)

Symptom	Yes	No	Symptom	Yes	No
Alcohol/drug problems	☐	☐	Gastro-intestinal problems	☐	☐
Arthritis	☐	☐	Hearing problems	☐	☐
Blood disorder	☐	☐	Heart disease	☐	☐
Breathing problems	☐	☐	HIV/AIDS	☐	☐
Cancer	☐	☐	Liver problems/Hepatitis	☐	☐
Diabetes	☐	☐	Mental illness	☐	☐
Pain	☐	☐	Urinary/kidney problems	☐	☐
Seizures/neurological problems	☐	☐	Vision Problems	☐	☐
Sleep disorder	☐	☐	Weight problems	☐	☐
Stroke	☐	☐	Other:	☐	☐
Thyroid problems	☐	☐	Other:	☐	☐
Tuberculosis	☐	☐		☐	☐

Do you have any allergies (food, medications, chemicals)? ☐Yes ☐No

If yes, list allergies: ____

Have you ever experienced an eating disorder, such as bulimia, anorexia or overeating? ☐Yes ☐No

Have you seen a physician in the past year? ☐Yes ☐No Date of last appointment? ________________

Primary Physician: ____ Phone: ___________________

Are you pregnant? ☐Yes ☐ No Number of dependent children: __________

<u>Current</u> Medications (prescribed and non-prescribed):

Name of Medication	Dosage	Frequency	Prescriber	Helpful?

Past Medications (no longer using)

Name of Medication	Dosage	Frequency	Prescriber	Helpful?

SUBSTANCE ABUSE HISTORY

Substances Used	Age of Onset	Current Use	Amount	Tolerance	Method (Oral, Smoke ,IV)	Withdrawal	Date Last Used	Family Members with Problem
☐ Tobacco		Y N		Y N		Y N		
☐ Alcohol		Y N		Y N		Y N		
☐ Marijuana		Y N		Y N		Y N		
☐ Cocaine		Y N		Y N		Y N		
☐ Methamphetamine		Y N		Y N		Y N		
☐ Hallucinogens		Y N		Y N		Y N		
☐ Inhalants		Y N		Y N		Y N		
☐ Opioids		Y N		Y N		Y N		
☐ Synthetic Marijuana(Spice)		Y N		Y N		Y N		
☐ Stimulants		Y N		Y N		Y N		
☐ Tranquilizers		Y N		Y N		Y N		
☐		Y N		Y N		Y N		

If multiple use, which substance is preferred: ____

Have you ever had a gambling problem? ☐No ☐Yes: how much money do you spend each month?

Have you ever had a problem with impulsive behavior? : ☐No ☐Yes

Have you ever used drugs intravenously? : ☐No ☐Yes Date of last IV Use: _______________

How long was you last period of voluntary abstinence? ___________________ When: _________________

Have you ever received formal treatment for a substance abuse problem? ☐Yes ☐No

Name of Treatment Provider | Year | Length of Program | Outcome

1.) ___________________________________ _________ _______________ ____________________

2.) ___________________________________ _________ _______________ ____________________

3.) ______________________________ ________ ______________ ___________________