

## APPOINTMENT SCREENING FORM

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Rank: \_\_\_\_\_ SSN: \_\_\_\_\_ Unit: \_\_\_\_\_

Home Address: (if not AIT student) \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Please answer the following questions: (If "yes," please explain)**

Are you currently considering suicide?  No  Yes: \_\_\_\_\_

Are you currently considering homicide?  No  Yes: \_\_\_\_\_

Do you feel hopeless?  No  Yes: \_\_\_\_\_

Do you feel helpless?  No  Yes: \_\_\_\_\_

Do you feel rageful?  No  Yes: \_\_\_\_\_

Have you been acting recklessly and/or engaging in risky activities?  No  Yes: \_\_\_\_\_

Have you been threatening to kill or hurt yourself?  No  Yes: \_\_\_\_\_

Have you been talking to others about dying or suicide?  No  Yes: \_\_\_\_\_

Have you been looking for ways to kill or hurt yourself?  No  Yes: \_\_\_\_\_

Have you been threatening to kill or hurt other people?  No  Yes: \_\_\_\_\_

Have you increased your use of alcohol?  No  Yes: \_\_\_\_\_

Are you withdrawing from friends, family and the community?  No  Yes: \_\_\_\_\_

Do you feel anxious?  No  Yes: \_\_\_\_\_

Do you feel agitated?  No  Yes: \_\_\_\_\_

Have been having trouble sleeping?  No  Yes: \_\_\_\_\_

Do you find yourself sleeping for more than is normal for you?  No  Yes: \_\_\_\_\_

Are you experiencing mood changes?  No  Yes: \_\_\_\_\_

Are you hearing voices when you know no one is there?  No  Yes: \_\_\_\_\_

Are you seeing things that you know do not exist?  No  Yes: \_\_\_\_\_

Is there anything else occurring in your life that you believe we should know to help us help you better? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**KAHC Community Behavioral Health Patient Intake Form**

**IDENTIFYING INFORMATION:**

**TODAY'S DATE:** \_\_\_\_\_

<input type="checkbox"/> Permanent Party <input type="checkbox"/> AIT <input type="checkbox"/> Activated Reservist/Guardsman <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> USMC <input type="checkbox"/> Coast Guard <input type="checkbox"/> PHS			
Name	Rank:	SSN:	DOB:
Ethnicity:		Marital Status:	# of Children:
Month/Day/Year Entered Service:	Time in Grade:	Time in Unit:	Unit:
ISG:		Commander:	Phone:

**REFERRAL:**

<input type="checkbox"/> Command <input type="checkbox"/> Self <input type="checkbox"/> Chaplain <input type="checkbox"/> Medical <input type="checkbox"/> Other _____				
Please describe the issue(s) that brought you here today?				
These issue(s) have been going on for approximately how long?				
Have you sought help previously?		Where?		
Is the problem deployment related?				
Please list dates and places of all deployment(s)?				

**FAMILY PSYCHIATRIC & MEDICAL HISTORY:**

Does any biological relative have any serious medical or psychiatric problems?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (who/what problem?):
Who raised you?	I grew up with ___ brother(s) ___ sister(s) ___ 1/2 brother(s) ___ 1/2 sister(s) I am the youngest/oldest/2 <sup>nd</sup> /3 <sup>rd</sup> /4 <sup>th</sup> /5 <sup>th</sup> /6 <sup>th</sup> /7 <sup>th</sup> of _____ siblings (circle one)
Describe what your family environment was like:	

**DEVELOPMENTAL HISTORY:**

Did you have any developmental problems when growing up? <input type="checkbox"/> No <input type="checkbox"/> Yes: Explain
Did you have any learning problems? <input type="checkbox"/> No <input type="checkbox"/> Yes
Did you receive any educational assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes
Were you ever diagnosed with any childhood condition/disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, what was it and what treatment did you receive?

**MEDICAL & MEDICATION HISTORY:**

Do you have any present chronic medical conditions?  No  Yes (list):

Are you being treated for them at this time?  No  Yes

Are you currently undergoing a MEB or MMRB?  No  Yes

Are you experiencing any pain?  No  Yes (where?):

How bad is the pain? (circle a number) 0 1 2 3 4 5 6 7 8 9 10  
 None Mild Moderate Severe Worst possible

How long have you had this pain? Have you seen anyone for it?  No  Yes:  
 If yes, what were the results?

Has the pain been:  Intermittent  Situational  Constant

Have you ever been hospitalized?  No  Yes: For what & how long?

Have you ever had surgery?  No  Yes: For what?

Have you ever had a significant head injury?  No  Yes: Did you lose consciousness?  No  Yes  
 Estimated time of unconsciousness: \_\_\_\_\_

Do you have any allergies, to include medications?  No  Yes: What?

Are you currently taking medications?  No  Yes: If yes, what are the names of the medications and what are they for?

Are you currently taking vitamins/herbal supplements?  No  Yes: what for? what type?

Have you had an unexpected weight gain/loss in the last 3 months?  No  Yes: How Much?

Do you have any problems eating/swallowing?  No  Yes: What?

**ALCOHOL/SUBSTANCE ABUSE HISTORY:**

Do you use any of the following substances:	<u>Alcohol</u>	<u>Tobacco</u>	<u>Caffeine</u>	<u>Illegal Drugs</u>
	<input type="checkbox"/> Now <input type="checkbox"/> In the Past <input type="checkbox"/> Never	<input type="checkbox"/> Now <input type="checkbox"/> In the Past <input type="checkbox"/> Never	<input type="checkbox"/> Now <input type="checkbox"/> In the Past <input type="checkbox"/> Never	<input type="checkbox"/> Now <input type="checkbox"/> In the Past <input type="checkbox"/> Never
Have you ever been in trouble because of your use?	<input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/> No <input type="checkbox"/> Yes
If "Yes", what kind of trouble and when?				
Have you ever been treated because of your use?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, what kind of treatment and when?	_____			
Do you use any other substances not listed above? (e.g., dipping, snuff, energy drinks, OTC energy capsules, caffeine pills, etc?) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list:	_____			
Do you want to reduce the amount you use or quit?	<input type="checkbox"/> No <input type="checkbox"/> Yes			

**SOCIAL/OCCUPATIONAL HISTORY AND FUNCTIONING:**

What activities are you involved in for fun outside of work?

Do you currently have friends to talk to about personal things?  No  Yes: Ever have such friends?  No  Yes  
 Do you find it difficult to make friends?  No  Yes

Do you get along with your coworkers?  No  Yes: If no, what is preventing this?

Do you enjoy your job?  No  Yes  
 What is the most enjoyable job you have ever had?

If you could change something about your current job, what would it be?

What job(s) did you have prior to coming on active duty?

**PSYCHIATRIC HISTORY:**

Have you ever been seen for a mental health concern before today?  No  Yes  
 If yes, what type of services did you receive? Were you prescribed medications? If yes, what type?

Did the treatment help reduce the problem?  No  Yes If no, explain:

**EDUCATIONAL/VOCATIONAL:**

What is your highest level of formal education? \_\_\_\_\_ Which did you earn?  GED  H.S. Diploma  
 What additional education or training do you want to receive?

Check your preferred methods of learning:  Hands-on  Reading  Classroom  Online  Discussion  Other  
 Check any limitations that may impede your learning:  Verbal  Hearing  Sight  Language  Physical  Other

**MILITARY SERVICE:**

What is your MOS? _____	Are you currently working in your MOS? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have any other MOS? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list: _____ Have you ever changed your MOS? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, why? _____ Are you currently assigned to WTU? <input type="checkbox"/> No <input type="checkbox"/> Yes What is your General Technical Score? _____
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**LEGAL/FINANCIAL HISTORY:**

Have you ever been in trouble with the law enforcement authorities?  No  Yes: If yes, how old were you and what alleged offense(s) were you charged with? \_\_\_\_\_

Have you ever had any UCMJ problems?  No  Yes: When and for what: \_\_\_\_\_

Are you pending any UCMJ problems?  No  Yes: Explain: \_\_\_\_\_

**NUTRITIONAL ASSESSMENT:**

Please read each statement. Circle the number in the YES column for all statements that apply to you:

	YES
1. I have an illness or condition that has made me change the type and/or amount of food I eat....	2
2. I eat fewer than 2 meals per day.....	3
3. I eat few fruits, vegetables, or milk products.....	2
4. I have 3 or more drinks of beer, wine or liquor almost every day (circle type).....	2
5. I have tooth or mouth problems that make it hard for me to eat.....	2
6. I don't always have enough money to buy the food I need.....	2
7. I eat alone most of the time.....	1
8. I take 3 or more different prescribed or over-the-counter drugs per day.....	1
9. Without wanting to, I have lost or gained 10 lbs. in the last six months .....	2
10. I am not always physically able to shop, cook or feed myself.....	2
	Total _____

- |   |  |
|---|--|
| 1. Are you having frequent nausea or vomiting of more than 3 days duration? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Do you ever binge eat or compulsively overeat?                           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Do you ever purge? (make yourself vomit)?                                | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. Have you been experiencing diarrhea or constipation for more than 3 days | <input type="checkbox"/> No <input type="checkbox"/> Yes |

**SPIRITUAL/RELIGIOUS/CULTURAL ASSESSMENT:**

- Check all of the characteristics that apply to you currently:
  - Losing my earlier faith / religion
  - Not going to church often enough
  - Not getting satisfactory answers from my faith
  - Needing to talk with a chaplain / pastor
  - None of the above
- How much is your religion / spirituality a source of strength and comfort to you?
  - Not at all  Somewhat  A moderate amount  Quite a bit
- How important is religion / spirituality in your daily life?
  - Not at all  Somewhat  A moderate amount  Quite a bit
4. Has your present problem / illness affected your spiritual life?  No  Yes If yes, how? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
5. Do you have any religious / spiritual practices that our providers need to be aware of during treatment?  
 No  Yes If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Has your ethnic/cultural background contributed in any way to your need for services today?  No  Yes  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**TRAUMA HISTORY:**

Have you ever experienced: Verbal abuse?  No  Yes Emotional abuse?  No  Yes Neglect?  No  Yes

If yes, by whom? \_\_\_\_\_

Have you ever experienced: physical abuse?  No  Yes

If yes, by whom? \_\_\_\_\_

Have you ever experienced sexual abuse?  No  Yes

If yes, by whom? \_\_\_\_\_

Have you ever been involved in a situation where you witnessed the death of another person, or thought you might die?  No  Yes Describe: \_\_\_\_\_

**History of Domestic Violence**

Have you ever witnessed physical violence between your parents?  No  Yes

Have you ever been physically assaulted by your mate?  No  Yes

Have you ever physically assaulted your mate?  No  Yes

**History of Loss**

Please list the important people in your life who have died?

Name	Relationship To You	Date Person Died	Cause of Death

Are you still grieving any of these losses?  No  Yes If yes, who? \_\_\_\_\_

**Significant Events:**

Has there ever been a particularly meaningful event or person in your life that helped you cope with difficult times?  No  Yes If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**STRENGTHS & WEAKNESSES:**

Please list your 3 greatest strengths: \_\_\_\_\_

Please list your 3 greatest challenges/weaknesses? \_\_\_\_\_

\_\_\_\_\_

**TRAINING:**

Have you attended Suicide Prevention Training?  No  Yes If yes, when and where? \_\_\_\_\_

\_\_\_\_\_

**TBI SCREENING:**

Did you have any injury(ies) during your deployment from any of the following? (check ALL that apply)

- Fragment
- Bullet
- Vehicular (any type of vehicle, including airplane)
- Fall
- Blast (IED, RPG, Land Mine, Grenade, etc.)
- Other: (specify) \_\_\_\_\_

Did any injury received while you were deployed result in any of the following? (check ALL that apply)

- Being dazed, confused, or "seeing stars"
- Not remembering the injury
- Losing consciousness (knocked out) for less than a minute
- Losing consciousness for 1-20 minutes
- Losing consciousness for longer than 20 minutes
- Having any symptoms of concussion afterward (such as headache, dizziness, irritability, etc.)
- Head injury
- None of the above

Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion: (check ALL that apply)

- Headaches
- Dizziness
- Memory Problems
- Balance Problems
- Ringing in the ears
- Irritability/Angry Outbursts
- Sleep problems
- Other: (specify): \_\_\_\_\_

\*\*\*

*Thank you for your time and thoughtfulness in completing this form.  
It will help us serve you better.*

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DIVISION OF BEHAVIORAL HEALTH

NO-SHOW POLICY

KENNER ARMY HEALTH CLINIC

FT LEE, VIRGINIA

The providers and staff of the Division of Behavioral Health Services strive to provide the best quality of service possible, in a timely manner for each of our patients. Part of this process requires that patients show up for their appointments, show up at least 15 minutes prior to the scheduled time, and complete updated paperwork as needed. When a patient does not show or call to cancel, less than 24 hours prior to their scheduled appointment time, we are unable to schedule someone else into that slot. This creates a delay in the time in which other appointments can be scheduled.

We realize that emergencies occur and schedules change. Due to this, please be aware of the following clinic policy:

- a. If you NO-SHOW for your appointment once, you will be granted a grace, but it will be annotated in your medical record.
- b. If you NO-SHOW a 2<sup>nd</sup> time, an annotation will again be made in your medical record and any future appointments could be significantly delayed. For AIT NO SHOW's – Command will be called. A 2<sup>nd</sup> NO SHOW will result in you requiring an escort for future appointments.
- c. NO-SHOW appointments are tracked through Kenner Army Health Clinic and these statistics are reported to Command Staff.
- d. For Permanent Party personnel: If the provider determines you are a safety concern, and you no-show, we may have to call your command if you do not respond to us immediately when we try to contact you. It is your responsibility to insure we have your correct contact numbers to reach you in a timely manner.

You may call to confirm your appointment if needed, and if you have to cancel, you may reschedule by phone (Provided you do not fall into category b above), but you must cancel prior to 24 hours before the appointment. When necessity dictates, and your scheduled provider is not available, we will contact you to reschedule your appointment with the 1<sup>st</sup> available slot. Please know that you may have to wait MORE THAN TWO WEEKS before getting another appointment when you call to reschedule.

Please help us to continue to serve you well by planning accordingly, arriving on time and completing updated paperwork with your contact information should we need to call you.

I have read the above and understand the NO-SHOW Policy for the Behavioral Health Services.

---

Patient Signature

SSN

Date



**Kenner Army Health Clinic**  
**Behavioral Health Services**  
**Fort Lee, Virginia 23801**



**INFORMED CONSENT OF TREATMENT  
AND LIMITS OF CONFIDENTIALITY**

Services are provided within the Department of Behavioral Health by service providers with varying backgrounds. They include Clinical Psychologists, Psychiatrists, Social Workers, and Psychiatric Nurse Practitioners, as well as providers in a training status (e.g., interns, externs, residents, etc), and other paraprofessionals whose services are supervised by a licensed provider. Your service provider should identify his or her professional status, identify any individuals providing supervision, and discuss any concerns you may have regarding your care. Patient signature below constitutes consent for DBH evaluation, treatment and interventions.

All providers within the Department of Behavioral Health insure the confidentiality of the information disclosed by their patients within the limits described below. In most cases, when patient information needs to be disclosed, the patient's permission is obtained prior to disclosure. These include disclosure as permitted by the Federal Privacy Act, by law, by regulation, by judicial proceeding, by Medical Quality Assurance Review, and by standards of ethical professional practice. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent.

1. If a provider believes that you intend to harm yourself or someone else, it may be the duty of that provider to disclose that information for protection of the endangered person(s).
2. In legal situations of suspected child, spouse, or elder abuse/neglect, it is the duty of the provider to notify medical, legal or other authorities.
3. If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court. Under the Uniform Code of Military Justice (UCMJ), medical personnel do not have "privileged communication" and thus are not exempt from mandatory disclosure in court.
4. Another member of the military medical system who is providing care to you and has a legitimate need to access information in order to provide safe and competent care may be permitted access without your consent. This includes credentialed providers assigned to ASAP.
5. Active Duty personnel may have their leadership chain contacted to provide information in certain situations. Examples include: if the consultation is initiated by a Command Directed Referral, Fitness for Duty, and/or chapter separation action if legitimately needed for line of duty investigation, or if you fall under the Nuclear Surety Program.
6. Qualified persons may be permitted access to your record as part of a professional Quality Assurance Review Procedure. Any information disclosed by the reviewer conceals the identity of the patient.
7. If you attend group therapy, group members will be informed that anything discussed will remain private, to include members' names. Information should not be discussed with anyone outside of group. Confidentiality will exist to the extent that each group member respects the privacy of all others.

**STATEMENT OF UNDERSTANDING**

I have read the above and understand the nature of service providers and the limits of confidentiality outlined above and in the Privacy Act Statement.

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**SERVICE PROVIDER'S STATEMENT**

I have inquired to ensure that the patient understood the above description of the Limits of Confidentiality and informed the patient if I am under supervision and by whom.

\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
Date

**PRIVACY ACT STATEMENT - HEALTH CARE RECORDS**

*THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.*

**1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**

**Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.**

**2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**

**This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.**

**3. ROUTINE USES**

**The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.**

**4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION**

**In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.**

**This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.**

**Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.**

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE

# Fort Lee Community Mental Health

## Mission Statement

The primary mission of Fort Lee Community Mental Health (CMH) is to evaluate, treat, and return service members back to their *units* as quickly as possible. CMH is dedicated to providing the best and most efficient assessment and treatment of service members that we possibly can. It is *important* for any service member seeking services at CMH to understand what services we can and cannot provide.

1. CMH does not have the authority to administratively discharge (Chapter) service members from the military. CMH will not make any attempts to initiate Chapters with Commanders at the request of service members. If you are seeking discharge from the military, you must discuss the issue with your Commander. Only your Commander has the authority to discharge you from the military.
2. CMH does support Commanders who refer service members for *Mental Status Evaluations* as part of the Chapter process. If you have been Command Referred, you should be aware that CMH will respond to your Commander in writing. *Mental Status Evaluations* most commonly include your diagnosis and any treatment recommendations (if applicable). CMH does not make decisions on whether or not a Chapter should be completed. CMH only states whether or not you meet criteria for a certain Chapter and/or if you are mentally competent to proceed with a Chapter.
3. Regardless of whether you are being discharged from the military or not, CMH can provide you with mental health treatment *as long as* you are at Fort Lee. Also, if you would like follow-up treatment once you leave Fort Lee (i.e., move to your next duty *station*), please inform your mental health provider so that we can help discuss follow-up care options with you.

## STATEMENT OF UNDERSTANDING

I have read the information above and understand the types of services that CMH can and cannot provide with regard to administrative discharges (Chapters), Mental Status Evaluations and treatment.

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PRINT NAME

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PATIENT'S SIGNATURE

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DATE

DIVISION OF BEHAVIORAL HEALTH

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FT LEE, VIRGINIA

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You may call to confirm your appointment if needed, and if you have to cancel, you may reschedule by phone (Provided you do not fall into category b above), but you must cancel prior to 24 hours before the appointment. When necessity dictates, and your scheduled provider is not available, we will contact you to reschedule your appointment with the 1<sup>st</sup> available slot. Please know that you may have to wait MORE THAN TWO WEEKS before getting another appointment when you call to reschedule.

Please help us to continue to serve you well by planning accordingly, arriving on time and completing updated paperwork with your contact information should we need to call you.

I have read the above and understand the NO-SHOW Policy for the Behavioral Health Services.

---

Patient Signature

SSN

Date

**MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA**

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE LIMITS OF CONFIDENTIALITY AND INFORMED CONSENT TO CARE (BH CLINICS)

OTSG APPROVED (Date)  
(YYYYMMDD)

For use of this form, see MEDCOM Suppl 2 to AR 40-66; the proponent agency is the Office of The Surgeon General.

As part of your healthcare team, our goal is to provide you with quality care as well as protect the privacy of your personal information. The care we provide you may include, but is not limited to: assessment, referral, individual therapy, couples therapy, family therapy, group therapy, and psychiatric evaluation and medications.

As your providers, we will document information about your visits in your military health record (written and electronic) to ensure continuity of care. Your health record is maintained as the property of the U.S. Government. In the majority of cases, we will not disclose any of your personal information nor confirm/deny that we have met with you unless you provide us with written authorization to disclose your personal information. There are just a few exceptions, however, under which we may be required to release your personal information without obtaining your prior authorization. However, we will discuss these with you at the beginning of treatment and throughout treatment, whenever possible. For example:

1. **Safety:** If you threaten to harm yourself, we may seek hospitalization and/or contact others to ensure your safety. If you threaten serious bodily harm to another, we are required to take protective actions, such as contacting the victim, police, chain of command, or seeking hospitalization.
2. **Abuse:** If we believe that a child, spouse, or vulnerable adult is being abused, we may be required to file a report.
3. **Legal:** If you are involved in legal actions/proceedings, your records may be subject to subpoena or lawful directive from a court. Under the Uniform Code of Military Justice (UCMJ), we have a limited "privileged communication" that may prevent your records from being disclosed in legal proceedings. This privilege is not absolute and there may be situations involving some violations of the UCMJ or civil law where we may be required to divulge that information to the chain of command and/or other authorities. If you have any concerns related to this, please contact an attorney.
4. **Fitness for Duty/Command-Directed Referrals:** If you are command-referred, your chain of command will not be authorized to view your medical record, but is entitled to limited information pertinent to any duty limitation or restriction, security clearance, or treatment that might affect duty performance or jeopardize the safety of yourself or co-workers.
5. **Care Coordination:** Because we operate as a team with other healthcare staff to provide you the best possible services, other members of the military medical system are permitted access to your record. In most cases, your information will not be disclosed outside the clinic/hospital setting without your written permission.
6. **Quality Care Review:** Quality assurance personnel may review your record to ensure that care standards are being met. If this occurs, the reviewer is required to keep your identity confidential.

If you have any questions or concerns, please feel free to discuss it with us.

**STATEMENT OF UNDERSTANDING/CONSENT TO ASSESSMENT and/or TREATMENT**

I have read the above and understand that clinical information about me will be safeguarded within the limitations mentioned above and under the provisions of the Privacy Act - DD Form 2005 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Patient/Caregiver Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I have explained the nature of the assessment and treatment(s) including benefits and risks of proposed and alternatives treatments.

(Continue on reverse)

PREPARED BY (Signature &amp; Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

 Click to Sign

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- |  |  |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL                | <input type="checkbox"/> FLOW CHART      |
| <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES              |  |
| <input type="checkbox"/> TREATMENT                       |  |