

St. Luke's Hospital
Children's Specialty Services
Intake Form

Child's Name _____ Date _____

Child's Date of Birth _____ Age _____

Form completed by: _____ Relationship _____

How does your child feel about attending the program? _____

Who does child live with and relationship _____

Parent/guardian _____

Address _____

Cell Phone _____ Work Phone _____

Employer/hours you work _____

Email address _____

Parent/guardian not in the home _____

Address _____

Cell phone _____ Work Phone _____

Others living in the household and relationship.

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

School Information

Name of attending school _____

Grade _____ General Ed _____ BD _____ Resource Room _____

Teacher or Contact Person _____

Phone Number _____

School Based Therapist _____

Phone Number _____

Does your child attend regularly? _____

Does your child have academic concerns at school? If yes, explain: _____

Does your child have an IEP? Yes ___ No ___ Academic ___ Behavioral ___

504 Yes ___ No ___

Mental and Physical Health History

Current Provider _____

Current Therapist _____

Current Primary Care Physician _____

Current Medical Diagnosis _____

Does your child wet or soil themselves? Yes ___ No ___

Has your child ever had an occupational therapy screen? Yes ___ No ___

Does your child appear to be seeking movement, touch, or deep pressure, (examples include spinning, rocking, consistently seeking hugs, biting arms or hands, putting non-food items in mouth, head banging, pulling own hair or heavy walking) Yes ___ No ___

Is your child bothered by noise, touch from others or tags in shirts, seams, avoids being messy, expresses distress with bathing or toothbrushing, bright or fluorescent lights? Yes ___ No ___

Does your child have difficulties with walking on carpet or uneven ground, running, kicking balls, catching balls, toileting independently? Yes ___ No ___

Does your child have any speech delays? Yes ___ No ___

Has your child ever been hospitalized on a psychiatric unit? When and where? _____

Has your child ever been in alternative placement? When and where? _____

Does your child currently have any other services? PHI _____ BHIS _____

Family Support Worker _____

Has Health and Human Services (DHS) been involved? If currently, list name and phone number of your worker _____

Any mental health history with mother or father? _____

Behavioral History

Describe past or current incidents of aggressive/assaultive behaviors in the home, at school or in the community.

What typically triggers your child to become angry and what does that look like?

Has your child ever attempted suicide or made suicidal threats? Yes ___ No ___ If yes, please describe:

Has your child ever been sexually abused? Yes ___ No ___ If yes, please share age, was the perpetrator family or friend and has your child received counseling as a result?

Does your child sexually act out in any way? Yes ___ No ___ If yes, recently, and how?

Has your child ever been physically abused, witnessed domestic violence, or neglected (left alone, been without food, clothing, or other basic needs)? Yes ___ No ___

Does your child currently have a probation officer? _____

Does your child have access to any firearms or other weapons in your home, a relative's home, or any other home they spend time at? Yes ___ No ___ If yes, are they locked up? _____

Are you currently practicing a religion? Yes ___ No ___ If yes, is there anything related to your religion that will interfere with your child's treatment? _____

Is there anything related to your cultural beliefs that will interfere with your child's treatment?

Yes ___ No ___ If yes, please describe _____

Nutritional Screen – Circle Only Those Numbers That Apply

My child follows a special diet – 3

If yes, describe _____

Most of the time my child eats alone – 2

My child takes 2 or more medications a day – 1

Parent/guardian is worried about the child's weight – 3

Sometimes my family does not have enough money to buy the food I need – 1

My child is pregnant or nursing a baby – 6

My child has tooth or mouth problems that make it hard to eat – 2

TOTAL THE SCORE _____

0-5 low nutritional risk 6+ high nutritional risk

Has your child gained or lost 10 lbs within the past 3 months? _____

Family and Peer Relationships

Name your child's strengths _____

Describe your relationship with your child _____

**Children's Specialty Services
St. Luke's Hospital Behavioral Health Services**

Patient Rights and Responsibilities

RIGHTS

1. The right to respectful care.
2. The right to be informed about their condition.
3. The right to informed consent.
4. To the extent permitted by law, the right to refuse treatment.
5. Within the context of appropriate care and safety, patients have the right to personal and informational privacy.
6. The right to request hospital services.
7. The right to confidential medical records.
8. The right to examine their bill.
9. The patient has the right to expect reasonable safety insofar as the hospital practices and environment are concerned.

RESPONSIBILITIES

1. The patient has the responsibility, to the best of their knowledge and ability, to provide pertinent personal information for their treatment.
2. The patient is responsible for following the treatment plan.
3. The patient is responsible for following the hospital and program rules.
4. The patient is responsible for being considerate of the rights of others in the program and staff.
5. The patient will be responsible for being respectful of the property of the hospital and others in the program.

CONFLICT RESOLUTION

Should you have a conflict related to the care of your child, please discuss this with the staff, the manager, or feel free to contact the Director of Behavioral Health Services.

Parent/guardian Signature

Date

CHILDREN'S SPECIALTY SERVICES MEDICAL INFORMATION FORM

Name _____ Date _____

Please list all medications your child is currently taking.

Date	Medication	Dosage	Route	Frequency	Will it be taken at the program	Comments

Medication Allergies _____

Food Allergies _____

Latex Allergy _____

Height _____ Weight _____

St. Luke's Children's Specialty Services

Engagement Model Philosophy

St. Luke's Children's Specialty Services, along with the rest of the Behavioral Health Division, utilizes what we call an "Engagement Model Philosophy". The basis for this philosophy centers on our common vision which is:

To create a place where kids, staff and parents want to be and where they can learn new skills that will benefit them now and in the future.

The basis for this vision revolves around the belief that everyone is here to learn new skills so they can better cope with life situations. We will do our best to assist your child in learning improved coping strategies so that they will be more successful in school, home, and in the community. Our goal is to be non-judgmental and to always focus on your child's strength.

Additionally, we will be mindful of every person's individual desire to make changes in their own time and in their own manner. Our goal will always be to give your child the tools to make more positive choices in their daily lives.

Safety will always be the top priority for all participants in our programs. Everyone will be given the opportunity to utilize positive coping strategies when they are feeling angry or frustrated. Each participant will complete a Safety Plan at the beginning of their treatment to better meet this goal.

If at some point your child is not able to use a coping strategy that maintains their safety and/or the safety of others (i.e., physical aggression towards self or others, destruction of property) all children's Specialty Services staff are trained to restrain children safely in order to keep them and others safe. Additionally, a child may be asked to take a time out in our time out room and in extreme situations parents will be called to pick up their child.

If the safety of your child or others is at imminent risk, if there is destruction of property, or if your child leaves the property, Cedar rapids Police Department may be called for assistance.

Parent Signature _____ Date _____

Child Signature _____ Date _____

Staff Witness _____ Date _____

St. Luke's Children's Specialty Services

Family Contract and Informed Consent

I agree to actively work with the treatment team to improve the condition of our family. I agree to make a good faith effort to achieve the following:

1. To consistently be available to and participate with the treatment team. I agree to attend sessions, to provide information, and discuss our family with those involved with the treatment interventions; including the physician, nursing staff, therapist(s), teacher, and social worker.
2. To participate at the first available opportunity in the family assessment, social history, and family therapy when requested.
3. To participate in sharing our opinions, thoughts and feelings about what I believe to be best for our family.
4. To participate in planning for discharge from the program.
5. To follow through with recommendations for services following discharge.

I understand that failure to follow through with the provisions of this contract may undermine the effectiveness of the services being provided to our family and may increase the risk of hospitalization or the need for other intensive psychiatric and/or mental health services.

Informed Consent

I understand that treatment outcomes may vary and that negative outcomes, including deterioration in my child's behavior and choices, are possible. Based on feedback we have received from families more than 85% of the children who attend our programs benefit from the treatment. I understand that failure to secure treatment at this point may result in a further deterioration in our child's behavior. I have also been informed that alternatives such as inpatient treatment, individual therapy, and residential treatment are available to us should this treatment fail. Having been fully informed of the benefits and potential risks of treatment I consent to the treatment of our child/adolescent.

Parent Signature Date

Parent Signature Date

Staff Witness Date

St. Luke's Hospital
Children's Specialty Services
Confidentiality Agreement

It is important that we have a safe and trusting environment. Information that is shared in the Children's Specialty Services needs to remain confidential. Outside of the program, communication between participants is discharged and discussion of specific issues is prohibited.

While in the program:

- **Program participants should not exchange phone numbers with each other.**
- **Program participants should not contact each other through social networking or e-mail (this includes Facebook, Twitter, Snapchat, Instagram, texting, e-mail, cell phones, land lines, etc.**
- **If we find that your child is communicating with fellow participants the following will occur:**
 - **Staff will meet with the youth and the parent and review the policy.**
 - **If it happens a second time dismissal may occur.**
- **All electronic devices must be turned off or turned in each day.**

Participant signature

Parent

Staff

Date

Children’s Specialty Services

Home Crisis Plan

If you feel your child is at risk of harming themselves or others while at home, you should:

- Make sure others in the home are safe
- You may call Foundation 2 Mobile Crisis Outreach at 319-362-2174
- If you feel there is an imminent safety risk, you may take your child to St. Luke’s Emergency Department for an evaluation to determine if they need to be admitted to our inpatient child/adolescent UnityPoint Health. If you need assistance transporting your child because of a safety concern, you may contact the police department for assistance
- Cedar Rapids Police Department – non-emergency number 319-286-5491
- Marion Police Department – non-emergency number 319-377-1511
- Or call 911

I have reviewed this plan and understand how to proceed if my child experiences a crisis while at home before or after program hours.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Staff Witness

Date

COMMUNITY AND SCHOOL-BASED SERVICES

Youth in crisis qualify for Mobile Crisis Outreach, J-FAST, and school-based services based on their location. Our providers are available to provide rapid, skilled support services for crisis situations including thoughts of suicide, self-harm, mental health-related hospitalizations, mental health concerns, and more.

Mobile Crisis Outreach

Available in Linn county

Mobile Crisis Outreach is intended for situations where a client would benefit more from a face-to-face meeting than from a call to the Foundation 2 crisis phone line. Those situations could include:

- Checking on an individual's safety or well-being
- Diffusing an emotional crisis
- Dealing with a family crisis or situation involving more than one person
- Assessing an individual in danger of attempting suicide

The team will **respond within one hour** of receiving a request (adverse weather conditions may delay response time). Private environments, like a person's home,

them. They felt the counselors did an excellent job of educating them on suicidal thoughts, and appreciated the time taken to safety plan so that they were comfortable. Anna said she felt secure by how seriously our team took the suicidal statements."

CALL NOW

Juvenile & Family Assistance & Stabilization Track (J-FAST)

Available in Linn county

Are you considering hospitalization or committal for a child (ages 8-18) due to mental health or substance abuse concerns? Are you unsure whether to call the police, hospital or DHS? J-FAST can meet with you to discuss options.

Issues we can help with include: depression, cutting, violent behavior, substance abuse, and thoughts of suicide. We can be at your Linn County location within an hour of your call.

Services include:

Immediate Crisis Response: A Foundation 2 Mobile Crisis Outreach team will respond to your home or child's school within 1 hour.

Assessment: Case management can help quickly schedule a mental health assessment or substance abuse assessment with a licensed therapist at one of our partnering agencies. (Linn County only)

School-Based Services

Available in the Cedar Rapids Community School District & Grant Wood AEA schools

Our dedicated CRCSD and Grantwood AEA case managers and trained crisis counselors help students and their families achieve and maintain stability. We report to all CRCSD schools, the hospital, and other locations within one hour of being contacted to provide crisis assessment and intervention services. We also offer comprehensive referral services to help students and their families access the on-going support they need. All services are confidential and free of charge.

How we help:

"A father voiced that during his child's hospital stay, the child's diagnosis had changed. Overwhelmed on how to proceed, he asked Foundation 2 to contact the school. The Foundation 2 caseworker communicated the changes to ensure an IEP meeting would be held. The parent expressed how thankful they were for the Foundation 2 caseworker's support."

"The Foundation 2 caseworker met with a student being discharged from the hospital to complete a safety plan. The student was able to complete the plan and discuss coping strategies they would like at school. The caseworker contacted school administrators and discussed allowing these coping strategies. The strategies have been utilized and proven successful."

CALL NOW

If Cedar rapids School District cancels or dismisses early for weather related reason, we will not have programming.

Always use discretion before traveling with or sending your child to program. If you have any reservations, please contact us. Please make sure your child is dressed appropriately for the weather.