Winchester Community
Mental Health Center, Inc.

MH/SA SCREENING PATIENT CONSENT PACKET
ADULT COMPLETION CHECKLIST (VIRGINIA)

☐ Copy of Photo I.D. and Insurance Card(s) given to Receptionist

☐ Urine Screen Analysis Consent Form

☐ Patient Consent & Service Agreement

☐ Limits of Confidentiality (Virginia)

☐ Notification of Client Rights (Virginia)

☐ Verbal Communication/Consent Release

☐ Tele-Therapy and Tele-Medication Limits of Confidentiality

☐ Informed Consent to Telehealth

☐ Advanced Directives

☐ Determination of Screening

Please complete this checklist and include this form when turning in paperwork from a screening appointment.

Staff Printed Name and Signature: _____

Date: _____

Winchester Community
Mental Health Center, Inc.

Patient Name: _____Date of Birth: _____ MR#: _____

Urine Screen Analysis Consent Form

All patients receiving medication management from Winchester Community Mental Health Center, Inc, ages 11 and above will be urine screened. There are no scientific tests to prove the presence of a psychiatric disorder. Instead, a diagnosis of a mental illness is based purely on professional expertise and the evaluation of symptoms, often following a 45-50-minute interview and without obtaining medical history from corroborating sources.

Urine Screen Analysis plays a valuable role in psychiatric treatment for the following reasons:

1. To complete a psychiatric assessment - Urine Analysis results can help psychiatrists conduct a more thorough and accurate assessment and pave the way to an effective treatment plan.

2. To monitor substance abuse – Additionally, some practitioners use Urine Analysis as a means to monitor ongoing issues with addiction. Doctors sometimes order urine screens to make sure that you are following medical advice.

3. To diagnose possible co-existing disorders – Substance abuse and psychiatric disorders often co-exist and determining the appropriate course of action is essential for successful treatment.

A psychiatric assessment that does not reflect results from a urine screen can lead to complications that patients and psychiatrists both want to avoid. Some of the risks of hiding drug use from a psychiatrist or psychiatric medication prescriber can include:

1. Misdiagnosis – For one, without factoring in evidence of drug use, a psychiatrist may misdiagnose a mental illness based on witnessing side effects from illegal drugs.

2. Exposure to psychiatric medications can have serious side effects. More concerning, misdiagnosis can lead to treatment for a nonexistent mental illness and expose a person to psychiatric medications with a known list of side effects that may cause mania, psychosis, depression, heart attack, stroke, and in extreme cases where a pre-existing heart condition may be present, even sudden death. In fact, some medications are just as powerful or addictive as illegal drugs like heroin, crack cocaine or methamphetamine.

3. Medical complications – Furthermore, patients using illegal drugs in combination with psychiatric drugs could experience additional, unforeseen side effects that misinform their diagnosis if all the contributing factors remain unknown.

Winchester Community Mental Health Center, Inc.

Patient Name: _____Date of Birth: _____ MR#: _____

Urine Screen Analysis Consent Form (CONTINUED)

1. I authorize the collection of this urine specimen for the purpose of an analysis of my drug levels. The analysis will be used to help my psychiatric clinician asses my medication treatment.

2. I acknowledge that the specimen will be tested in my presence for various psychiatric medications in addition to: Cocaine, Methamphetamines, Morphine, PCP (phencyclidine), THC, Marijuana, Suboxone, Methadone, and Benzodiazepines.

3. I understand that this is only a screening test and that further confirmation by the authorized medical laboratory will be necessary if results are not negative.

4. I authorize the collector to send the specimen to an authorized medical laboratory of WCMHC's choice.

5. I understand that the medical professional performing this test cannot answer questions or discuss the preliminary urine analysis results or methods used. Final test results will be available to me and I will have an opportunity to discuss them with my psychiatric clinician, if necessary.

6. I understand that urine drug screen may be observed by staff. This is to minimize misidentification of urine specimens and to ensure that the tested specimens can be traced to the donor patient.

Patients who refuse a Urine Screen Analysis are at risk for harm and may be terminated at the discretion of their clinician and/or the WCMHC Clinical Director from services at WCMHC, including medication management.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____
Witness Printed Name

_____ _____
Witness Signature Date

Patient Name: _____ Date of Birth: _____ MR #:_____

PATIENT CONSENT & SERVICE AGREEMENT

Voluntary Admission: I voluntary consent to admission at Winchester Community Mental Health Center and to treatment that may be recommended by my Physician and treatment team.

Consent for Services: I hereby authorize Winchester Community Mental Health Center to render appropriate services as prescribed by my Physician or by any other Physician who may be treating me. Including all diagnostic and therapeutic treatments that may be from considered advisable or necessary in the judgment of the Physician. I hereby release Winchester Community Mental Health Center all liability incurred as a result of medical treatments provided by the staff of the agency.

Emergency Medical: I understand that during the course of my treatment, the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. I understand that Winchester community Mental Health Center does not provide emergency medical care and therefore should the need for such treatment and/or transfer be necessary and appropriate by my physician, the center staff will call 911. I consent to such emergency treatment and/or transfer to a hospital and I hereby indemnify Winchester Community Mental Health Center and its owners and staff and physician who may be in attendance from any loss resulting such emergency treatment and or transfer. I agree to assume sole responsibility for all charges incurred for such treatment.

Nursing Care The facility provides only limited general duty nursing care during program hours. If patient's condition is such as to need continuous or special duty nursing care, care is the financial responsibility of the patient or his/her agent and not the facility. The facility shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from such additional nursing care.

Confidentiality and Release of Information:

I authorize all Physician, Hospitals, Nursing Homes, Clinics and or Health Care Providers to Release Medical information relevant to my care to Winchester Community Mental Health Center. I understand that all WINCHESTER staff must adhere to HIPPA rules and regulations and keep my information and any related matters confidential and may not release any information without my written consent. I hereby authorize the release of any of any medical information from my records to any licensed institution or agencies by Winchester Community Mental Health Center for the purpose of providing continuity of care. I place no limitations on history of illness or diagnostic/therapeutic information including any treatment for Substance abuse, Psychiatric Disorders, Acquired Immune Deficiency Syndrome.

Insurance Benefits: I hereby authorize my private insurance carrier to pay insurance benefits due me to Winchester Community Mental Health Center and agree to the release of medical information to my insurance carrier if I should be required by any

Patient Name: _____ Date of Birth: _____ MR #:_____

PATIENT CONSENT & SERVICE AGREEMENT

program. I also agree to be personally responsible for my deductions, co-insurance, or disallowance of payments.

Assignment of Benefits and Release of Medical Records to Intermediary for Reimbursement:

As a Medicare or Medicaid patient, I certify that the information given by me in applying for payment under the title XVIII or title XIX of the social security act is correct. ***I authorize release of my medical record, including psychotherapy notes, medical/clinical evaluations and progress notes, assessments, laboratory and radiology reports/findings, treatment plan, treatment & progress summaries, behavioral contracts and aftercare plan and other treatment referrals and billing information required to act on this request.*** I request that payment of authorized benefits be made to Winchester Community Mental Health Center on my behalf.

Personal Valuables: I understand that WINCHESTER Community Mental Health Center will not be liable for any loss or damage to any money, jewelry, eyeglasses, contact lenses, documents, and other articles of value that I chose to bring to the program.

Right to Search Personal Property:

I understand that WINCHESTER CMHC and WINCHESTER staff reserve the right to search any bags that I bring into the center, for my protection and for the safety of others upon suspicion of violations of agreements. I also understand that certain items may not be brought into the center, including, but not limited to weapons, including sharp objects; illegal drugs; alcohol; and any other contraband items.

Statement of Patients' Rights & Responsibilities and Abuse Registry:

I certify that I have read, understand and received a copy of the Patient Responsibilities, Rights of Patients, Program Rules and Regulations, Notification of Rights, which has been explained to me orally by a representative of Winchester Community Mental Health Center. I understand the policy and have received a copy of it with the toll-free abuse registry phone number.

Medications and Drugs: I agree to neither keep nor use any illegal or legal medication or drugs (including alcohol) not prescribed or approved by my physician. I agree to take all medications as directed. I understand and agree that the possession or use of any other medications if discovered by the WINCHESTER staff shall result in them being removed from me and being destroyed according to WINCHESTER CMHC policies and procedures. Any medication that I bring into the center must have the patient's name on it, and WINCHESTER staff must be informed that the medication is in the patient's possession.

Patient Name: _____ Date of Birth: _____ MR #:_____

PATIENT CONSENT & SERVICE AGREEMENT

I hereby certify that I have read and received a copy to the Patient Consent & Service Agreement and had all questions and concerns explained to my satisfaction and agree to these conditions of admission and consent for treatment.

_____
Patient Signature/Date

_____
Legal Guardian Signature/Date

_____
Witness Printed Name

_____
Witness Signature/Date

Winchester Community
Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

LIMITS OF CONFIDENTIALITY (VIRGINIA)

Federal and State of Virginia Laws and Regulations protect the confidentiality of client records maintained by this facility. Generally, the facility may not say that a client attends the facility or disclose any information identifying a client unless:

1. **Risk of self-harm**: During your session, if you present a threat level, words, or behavior that convince your therapist that you are likely to harm yourself, either deliberately or because you are unable to keep yourself safe, your therapist must do whatever he or she can to prevent you from being harmed
2. **Risk of harm to others**: During your session, if you present a threat level toward another person, words, or behavior that convince your therapist that you are likely to harm another person, your therapist must try to protect that person. He or she would report your threat to the police, warn the threatened person, and try to prevent you from carrying out your threat. Federal and State of Virginia Laws and Regulations do not protect any information about a crime committed or intent to commit a crime by a patient either to themselves or others.
3. If your therapist obtains information leading him/her to **believe or suspect abuse** of a child, senior citizen, or disabled person, the therapist must report this to a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. The therapist cannot investigate and decide whether abuse is taking place - if the suspicion is there, the therapist must report it. Federal and State of Virginia Laws and Regulations do not protect any information about suspected abuse and neglect from being reported.
4. **Children and adolescents**: It is the policy of this agency, when a therapist treats children and adolescents, to ask their parents or guardians to agree that most details of what their children or adolescents tell the therapist will be treated as confidential. However, parents or guardians do have the right to general information about how therapy is going. The therapist may also have to tell parents/guardians about information if their children or others are in any danger.
5. **Couples**: If one member of a couple tells a therapist something the other member does not know, and not knowing this could harm him or her, the therapist cannot promise to keep it confidential from the other person. If this occurs, the therapist will discuss it with you before doing anything else.
6. **In group therapy**: The other members of the group are not therapists. They are not bound by the ethical rules and laws governing therapists. To avoid problems in this area, it is this agency's policy to ask all members of therapy groups to agree to protect one another's confidentiality, and to remove from the group any member who does violate another member's confidentiality. Still, this agency cannot be responsible for such disclosures by other clients, and it may be better for you to discuss information you feel must be legally protected in an individual session with your therapist than in a therapy group session.
7. This agency will not record therapy sessions on audiotape or videotape without your written permission.
8. If a judge court orders your therapist to provide information about your history or your treatment, the therapist must do so as required by federal laws and/or regulations.
9. This disclosure is made to medical personnel in a medical emergency.
10. Your therapy and/or medication management clinician may consult with other Winchester Community Mental Health, Inc. therapy and/or medication management clinicians and/or supervisors to provide the best possible care. These consultations are for professional and training purposes only.

Violation of Federal and State of Virginia Laws and Regulations by a facility is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal and State of Virginia regulations.

Client Statement: I have read this information pertaining to the confidentiality of client records and understand it as written.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Staff Printed Name Staff Signature Date

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

NOTIFICATION OF CLIENT RIGHTS (VIRGINIA)

1. Receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) financial abuse, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats, and exploitation, and (e) all forms of seclusion and restraint.

2. Be fully informed about the course of your care and decisions that may affect your treatment.

3. Revoke your consent for treatment at any time.

4. Timely and accurate information to assist you in making sound decisions about your treatment

5. The right to be informed how to access self-help services, legal entities for appropriate representation, and advocacy support services.

6. Be fully involved as an active participant in decisions pertaining to your treatment.

7. The right to freedom from unnecessary or excessive medication.

8. Have an individual identified in writing that will direct and coordinate your treatment.

9. The right to be informed of and refuse any unusual or hazardous treatment procedures.

10. The right to agency adherence to research guidelines and ethics, if applicable.

11. Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations.

12. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.

13. File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort.

14. Have family members, friends or others involved in your treatment with your consent and approval.

15. Receive services that comply with all applicable federal and state laws, rules and regulations.

16. File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit.

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

NOTIFICATION OF CLIENT RIGHTS (VIRGINIA)

17. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay.

18. To request a transfer to another program if you believe you are not receiving care that is meeting your needs and preferences.

19. You may also have additional rights afforded to you based on federal, state, and local regulations.

Your service coordinator will advise you of any additional rights that you may have.

Please speak with the Clinical Director if you have concerns or problems with any of the Winchester Community Mental health Center, Inc. policies or staff. We want to serve and provide you with excellent service and respect.

Clinical Director: Mary Zirkle, MS, LPC (540) 535-1112
Or Complaint: 1-800-955-1819

If you are not satisfied with our solution or continue to have problems or concerns, please call your Local Human Rights Advocate.

Human Rights Advocate: Cassie Purtlebaugh (804) 382-3889

All clients have the right to a complaint resolution, hearing, and appeal procedure.

I also understand the following regarding Winchester Community Mental Health Center, Inc:

- All clients will be expected to cancel appointments with at least 48-hour prior notification.
- A fee will be charged upon request for completion of outside paperwork; payment must be confirmed prior to completion.
- All clients are expected to be on time to their appointments.
- No firearms, pellet guns, air rifles, or other weapons designed or intended to propel a missile of any kind by any action of explosion or combustible material allowed on premises.

Winchester Community Mental Health Center, Inc. is a private place of business. We do have the right to decline or terminate services if necessary.

The Human Rights have been explained to me and a copy of the Human rights and Regulations Booklet has been offered to me.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Witness Printed Name Witness Signature Date

REVISED 09.9.2022 HM

Winchester Community
Mental Health Center, Inc.

Client Name: _____ **Date of Birth:** _____ **MR#:** _____

VERBAL COMMUNICATION/CONSENT RELEASE

I, a patient of Winchester Community Mental Health Center hereby give consent for verbal communication by members of my Treatment Team to the following person(s):

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient: _____
Current Address: _____
Current Telephone #(s) _____

LIMITATION: Verbal communication is limited to information regarding my treatment program. This authorization does not authorize dissemination of any portion of my medical record. This authorization is valid for the term of my treatment at Winchester Community Mental Health Center, plus ninety (90) days post discharge; unless revoked by me in writing, prior to that date. I hereby release Winchester Community Mental Health Center and all members of my treatment team from any liability which may arise as a result of information provided per the terms of this authorization.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Staff Printed Name Staff Signature Date

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

Tele-Therapy and Tele-Medication
Limits of Confidentiality

What is Teletherapy or Telehealth/Tele-Medication?
Teletherapy, Telehealth/Tele-Medication, involves the use of electronic communications to enable physicians and other healthcare professionals, including mental healthcare professionals, to improve the access to quality and appropriate care. Teletherapy includes the practice of health-care delivery, evaluation diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Treatment Providers may include, but are not limited to, psychiatrists, psychologists, nurses, counselors, clinical social workers, and marriage and family therapists.
Teletherapy services are also available for face-to-face clients on an as needed basis if deemed to be necessary and appropriate for treatment. At this time teletherapy services are only being offered via videoconferencing and the telephone.

Risks and Benefits
In addition to the risks and benefits outlined in the Informed Consent, Teletherapy has its own unique risks and benefits. Benefits include improved access to care for clients who are homebound, lack reliable transportation, or do not have providers near them. Teletherapy can be beneficial for those who are more comfortable communicating online rather than face to face. Teletherapy often offers more flexibility with scheduling. Risks include but aren't limited to unexpected technological failures during sessions; increased risks to privacy which creates an additional burden on the client to ensure that sessions are private and undisrupted; hacking. An important risk to consider is the lack of nonverbal communication (body signals) that are readily available to both therapist and client in face-to-face sessions. Without this information, teletherapy may be slower to progress or be less effective altogether.

Client Records
All records are kept in written, hard copy form and stored at Winchester Community Mental Health Center located in Winchester, VA or Inwood, WV. All records are stored for seven (7) years. Clients and Parents/Legal Guardians of Minor Clients have the right to request a copy of the record or a brief summary. All records request must be submitted in writing and are subject to a fee.

Verification of Client Identity
At the initial session the client will be required to provide proof of identity.

Technological Failures
Should a video or telephone session experience a disruption/technological failure the therapist will re-establish the connection (place a new video or telephone call) unless other arrangements between client and therapist are agreed upon. If videoconferencing is temporarily unavailable the session will resume via telephone (in accordance with the client's consent for communication form.) If after 15 minutes connection can't be re-established, or the session resumed on the phone then the session will be rescheduled. If the technological failure occurs on the therapist's end the client will not be charged for the appointment; if the failure occurs on the client's end, they are still subject to the full session fee (pro-rated session rates not available).

Emergencies
Emergency procedures laid out in the Informed Consent form apply. Given that therapy is not being conducted face to face, I do require all teletherapy clients have an emergency contact on file (additional release will be provided).

Winchester Community Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR#: _____

Tele-Therapy and Tele-Medication
Limits of Confidentiality

Best Practices

To create an environment that is as close to a face-to-face experience as possible the following guidelines are strongly recommended:

A. Ensure that your location is private and secure. Try to conduct your session in a room that allows you to separate yourself from distractions and any non-participants in the home who might overhear. Make arrangements for childcare if possible.

B. If the session is being conducted through video chat:

a. Make sure there is enough lighting. Dark and solid colored clothing works best and lowers risk of interference with video image. Avoid large pieces of jewelry that reflect light. Take off hats and sunglasses that limit the view of your face.

b. Only use a Wi-Fi network that is secure via password protection, no public Wi-Fi

c. Position yourself and camera so that you are visible from at least the waist up. If there are multiple participants make sure everyone is in view.

I understand that teletherapy services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic and/or medication management services (e.g. face-to-face services) I will be referred for face-to-face sessions.

I understand that there are potential risks and benefits associated with any form of medication management and/or psychotherapy, and that despite my efforts and the efforts of my medical provider and/or therapist, my condition may not improve, and in some cases may even get worse.

I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my medical provider and/or therapist.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy.

I understand that the information disclosed by me during my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality as outlined in the main informed consent form.

I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my consent.

I understand that I have the right to withhold or withdraw my consent to the use of teletherapy and/or Tele-Medication during my care at any time, without affecting my right to future care or treatment.

_____ _____

Signature of Client Date Signature of Parent/Advocate Date

_____ _____

Staff Printed Name Staff Signature Date

Winchester Community
Mental Health Center, Inc.

Client Name: _____ Date of Birth: _____ MR# _____

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my medication management and therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in medication management and/or psychotherapy via telephone or the videoconferencing (hereinafter referred to as Telehealth).

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person medication management and/ or psychotherapy. Any information disclosed by me during my session, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person.

I also understand that if I am a danger to myself or others, my healthcare provider has the right to break confidentiality to prevent the threatened danger.

Further, I understand that the dissemination of any personal and/or identifiable images or information from the Telehealth interaction shall not occur without my written consent.

I understand that while medication management and/or psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that treatment will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our telehealth sessions could be interrupted by technical failures.

In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a healthcare provider in my geographic area that can provide such services. I have read and understand the information provided above.

I have the right to discuss any of this information with my healthcare provider and to have questions regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications at any time by providing written notification to WCMHC.

My signature below indicates that I have read this Agreement and agree to its terms.

Client's Signature: _____ Date_____

Parent/Legal Guardian's Signature: _____ Date_____

Clinician Printed Name and Credentials: _____

Clinician Signature: _____ Date_____

Supervisor Printed Name and Credentials: _____

Supervisor Signature: _____ Date_____

REVISED 06.16.2022 HM

Winchester Community
Mental Health Center, Inc.

Client's Name: _____ Date of Birth: _____ MR#: _____

ADVANCED DIRECTIVES

Location of Services (Please *select one*):
☐ 36 Ricketts Drive Winchester, VA 22601
☐ 105 Stony Pointe Way Strasburg, VA 22657
☐ 123 Hovatter Drive Inwood, WV 25428

Advanced Directives:
I have received written information regarding my rights to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate Advance Directives under state law. (Please see the Client Handbook and the Human Rights and Regulations form)

Client has developed an Advanced Directive: ☐ Yes ☐ No

If no, stop here and let the client know that assistance in developing an Advanced Directive is available through various national and state resources, such as www.caringinfo.org.

If an Advanced Directive has been executed it is in the medical record, unless the client does not wish to have it filed.

☐ Client declined Advanced Directives.

Client has a living will: ☐ Yes ☐ No

If yes, location of Living Will: _____
I have a patient advocate/ proxy is:
Name: _____
Address: _____
Phone: _____

☐ I do not desire to complete a durable power of attorney for health care
☐ I do desire to complete a durable power of attorney for health care
☐ I have a Durable Power of Attorney for health care

☐ I have a directive to physicians
☐ I desire to complete a directive to physicians
☐ I do not desire to complete a directive to physicians

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____ _____
Staff Printed Name Staff Signature Date

REVISED 04.27.2023 HM

Winchester Community Mental Health Center, Inc.

Patient Name: _____ Date of Birth: _____ MR#: _____

DETERMINATION OF SCREENING

☐ **Partial Hospitalization Program Services (ONLY PROVIDED AT WINCHESTER, VA OFFICE LOCATION)**:

☐ Winchester, VA Office:

☐ Mental Health: Mon, Tues, Wed, Thurs, Fri. 9:00 am to 1:00 pm

☐ Substance Abuse: Mon, Tues, Wed, Fri. 9:00 am to 2:00 pm

- Patient has a diagnosed or suspected mental illness.
- Patient has serious, acute, and identifiable symptoms and/or behavioral manifestations of such severity that there is significant interference with social, vocational, and/or educational functioning.
- The patient can reliably plan for safety in a structured environment for the rest of the time.
- The patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.
- The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided by a hospital level of care.

☐ **Intensive Outpatient Program Services:**

☐ Winchester, VA Office:

☐ Mental Health: Mon, Wed, Fri. 9:00 am to 12:00 pm

☐ Substance Abuse: Mon (9 am to 1 pm), Tues (9 am to 12 pm), Wed (9 am to 1 pm), Fri. (9am to 12 pm)

☐ Substance Abuse Adolescent: Mon, Tues, Wed, Thurs. 4:00 pm to 7:00 pm

☐ Mental Health Adolescent: Mon, Wed, Thurs 4:00 pm to 7:00 pm

☐ Strasburg, VA Office:

☐ Substance Abuse Adolescent: Mon, Wed, Thurs 4:00 pm to 7:00 pm

☐ Mental Health Adolescent: Mond, Wed, Thurs 4:00 pm to 7:00 pm

☐ Inwood, WV Office:

☐ Mental Health: Mon, Wed, Thurs. 4:00 pm to 7:00 pm

☐ Substance Abuse: Mon, Tues, Wed, Thurs. 4:00 pm to 7:00 pm

☐ Substance Abuse Adolescent: Mon, Tues, Wed, Thurs 4:00 pm to 6:00 pm

☐ Mental Health Adolescent: Mon, Tues, Wed, Thurs 4:00 pm to 6:00 pm

- Patient has a mental health and/or substance abuse diagnosis.
- The patient presents with behavioral, psychological, and/or biological dysfunction and functional impairment consistent and associated with the psychiatric/substance related disorder.
- Patient does not need a higher/lower level of care.
- Patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

☐ **Outpatient Services: <u>Specify Frequency</u> next to each checked service:**

☐ Individual Counseling: _____ Times a week

☐ Case Management

☐ Mental Health Group *Winchester office ONLY

☐ Psychiatric Medication Management

☐ Community Based Services

☐ Intensive In-Home

☐ Mental Health Skills Building

☐ Other: _____

I understand that I must comply with all the identified services in order to receive continued care at WCMHC.

_____ _____

Patient Signature Date Witness Printed Name & Signature Date

REVISED 05.12.2023 HM

Winchester Community
Mental Health Center, Inc.

Patient Name: _____ Date of Birth: _____ MR#: _____

The clinical screening for Mental Health Services has determined that I am ineligible for services at WCMHC due to:

_____

☐ Referral source informed of determination and reasons for ineligibility (if applicable)
☐ Family informed of determination and reasons for ineligibility (if applicable)

Recommendations for alternative services:

_____
_____
_____
_____
_____
_____

I have been informed of my ineligibility and was given recommendations for alternative services.

_____
Patient Signature Date

_____
Witness Printed Name & Signature Date

REVISED 05.12.2023 HM