Catholic Charities Family and Community Services

Last Name: _____ **MI**: _____ **First Name**: _____

Preferred Name: _____ **Preferred Pronouns:** _____

DOB: _____**SSN**: _____ **Email Address**: _____

Address: _____ **Zip Code**: _____ **Phone**: _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email ☐ USPS letter **Religion**: _____

Race: ☐ African American ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Hawaiian or other Pacific Islander ☐ Hispanic or Latino ☐ White

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single (never married) ☐ Widowed

What is happening in your life that led you to coming here today? _____

_____

Have you been in treatment at CCFCS before? ☐ Yes ☐ No **If yes, when?** _____

Are you in need of immediate Medication Assisted Therapy for Substance Use? ☐ Yes ☐ No

Have you received any medications from another medical or treatment provider in the past month? ☐ Yes ☐ No

Are you currently experiencing withdrawal symptoms? ☐ Yes ☐ No

Please check all that apply to you:

☐ Depression	☐ Chest pain	☐ Delusions/hallucinations
☐ Low energy	☐ Trembling/shaking	☐ Not thinking clearly/confusion
☐ Low self-esteem	☐ Sweating	☐ Feeling that you are not real
☐ Poor concentration	☐ Chills/hot flashes	☐ Feeling that things around you are not real
☐ Hopelessness	☐ Tingling/numbness	☐ Unpleasant thoughts won't go away
☐ Worthlessness	☐ Fear of dying	☐ Anger/frustration
☐ Guilt	☐ Fear of going crazy	☐ Defying rules
☐ Sleep disturbances	☐ Nausea	☐ Blaming others
☐ Appetite disturbances	☐ Phobias	☐ Argumentative
☐ Thoughts of harming yourself	☐ Obsessions/compulsive behaviors	☐ Excessive use of drugs or alcohol
☐ Thoughts of harming someone else	☐ Racing thoughts	☐ Excessive use of prescription medications
☐ Isolation/social withdrawal	☐ Can't hold on to an idea	☐ Black outs
☐ Sadness/loss	☐ Easily agitated	☐ Physical abuse
☐ Anxiety/panic	☐ Spousal abuse	☐ Excessive behaviors (gambling, spending)
☐ Sexual abuse	☐ Learning Disability	☐ Intellectual or developmental disability

☐ Other _____

Patient Health Questionnaire – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor apptite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the oppisite - beinf so fidgety or restless that you could have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

* If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Generalized Anxiety Disorder Scale (GAD-7)

Over the last 2 weeks, have you felt bothered by any of these things?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge?	0	1	2	3
2. Not being able to stop or control worrying?	0	1	2	3
3. Worrying too much about different things?	0	1	2	3
4. Trouble relaxing?	0	1	2	3
5. Being so restless that it is hard to sit still?	0	1	2	3
6. Becoming easily annoyed or irritable?	0	1	2	3
7. Feeling afraid as if something awful might happen?	0	1	2	3

* If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Problem Gambling Severity Index

This self-assessment is based on the Canadian Problem Gambling Index.
It will help you decide if you wish to seek other forms of support or information.

When you think of the past 12 months, have you bet more than you could really afford to lose?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Still thinking about the last 12 months, have you needed to gamble with larger amounts of money to get the same feeling of excitement?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

When you gambled, did you go back another day to try to win back the money you lost?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have you borrowed money or sold anything to get money to gamble?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have you felt that you might have a problem with gambling?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Has gambling caused you any health problems, including stress or anxiety?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Has your gambling caused any financial problems for you or your household?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have you felt guilty about the way you gamble or what happens when you gamble?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Total your score. The higher your score, the greater the risk that your gambling is a problem.

Score of 0: Non-problem gambling.
Score of 1 or 2: Low level of problems with few or no identified negative consequences.
Score of 3 to 7: Moderate level of problems leading to some negative consequences.
Score of 8 or more: Problem gambling with negative consequences and a possible loss of control.

Ferris, J., & Wynne, H. (2001). The Canadian problem gambling index: Final report. Submitted for the Canadian Centre on Substance Abuse.

Fagerstrom Test for Nicotine Dependence (FTND)

Do you smoke? (Circle one) Yes No

If yes, please continue

	0	1	2	3
1. How soon after you wake up do you smoke your first cigarette?	After 60 minutes	31-60 minutes	6-30 minutes	Within 5 minutes
2. Do you find it difficult to refrain from smoking in places where it is forbiddden, e.g., in church, at the library, cinema, ect?	No	Yes		
3. Which Cigarette would you hate most to give up?	All others	The first one in the morning		
4. How many cigarettes/ day do you smoke?	10 or less	11-20	21-31	31 or more
5. do you smoke more frequently during the first hours of waking than during the rest of the day?	No	Yes		
6. Do you smoke if you are so ill that you are in bed most of the day?	No	Yes		

Rapid Opioid Dependence Screen (RODS)

1. Have you ever taken any of the following drugs? (circle yes or no)

Heroin	yes	no
Methadone	yes	no
Buprenorphine	yes	no
Morphine	yes	no
Fentanyl	yes	no
Oxycontin	yes	no
Oxycodone	yes	no
Other opioid analgesics (e.g. Vicodin, Darvocet etc.)	yes	no

If the response to any drug in question 1 is "yes", proceed to question 2 to 8.

If the response to all drugs in question 1 are "no", stop screening.

2. Did you ever need to use more opioids to get the same high as when you first started taking opioids?	yes	no
3. Did the idea of missing a fix (or dose) ever make you anxious or worried?	yes	no
4. In the morning, did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick"?	yes	no
5. Did you worry about your use of opioids?	yes	no
6. Did you find it difficult to stop or not use opioids?	yes	no
7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high?	yes	no
8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids?	yes	no

Name _____ ENGLISH
Date _____

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

During the last 6 months…

	Yes	No
1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) --- 1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)	----------	----------
2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)		

5. Have you had any health problems? Please check if you have:
   - ___ Had blackouts or other periods of memory loss?
   - ___ Injured your head after drinking or using drugs?
   - ___ Had convulsions, delirium tremens ("DTs")?
   - ___ Had hepatitis or other liver problems?
   - ___ Felt sick, shaky, or depressed when you stopped?
   - ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ___ Been injured after drinking or using?
   - ___ Used needles to shoot drugs?

Please continue ⇒

Name _____ ENGLISH
Date _____

Modified Simple Screening Instrument for Substance Abuse (continued)

	Yes	No
6. Has drinking or other drug use caused problems between you and your family or friends?		
7. Has your drinking or other drug use caused problems at school or at work?		

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)		
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?		
10. Are you needing to drink or use drugs more and more to get the effect you want?		
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone?		
13. Do you feel bad or guilty about your drinking or drug use?		

The next questions are about your lifetime experiences.

	Yes	No
14. Have you ever had a drinking or other drug problem?		
15. Have any of your family members ever had a drinking or drug problem?		
16. Do you feel that you have a drinking or drug problem now?		

Thank you for filling out this questionnaire.

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

- ☐ **I GIVE CONSENT for this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.
- ☐ **I DENY CONSENT for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

_____	_____	_____
Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
_____	_____	
Signature of Patient or Patient's Legal Representative	Date	
_____	_____	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
_____	_____	
Signature of Witness	Print Name of Witness	

Details about patient information in PSYCKES and the consent process:

1. How Your Information Can be Used. Your electronic health information can only be used by your treatment provider to:

- Provide you with medical treatment, care coordination, and related services
- Evaluate and improve the quality of medical care provided to all patients
- Notify your treatment providers if you have an emergency (e.g., go to an emergency room)

2. What Types of Information About You Are Included? If you give consent, _____ can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES may include information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Care plans, safety plans, and psychiatric advanced directives you and your treatment provider may have developed may also be included. This information may relate to sensitive health conditions, including but not limited to:

- Mental health conditions
- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Sexually transmitted diseases

3. Where Health Information About You in PSYCKES Comes From. If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be entered by you or your treatment provider. Health information from other databases maintained by NYS is also included in PSYCKES. New health databases may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see “About PSYCKES” or ask your treatment provider to print the list for you.

4. Who May Access Information About You, If You Give Consent. Only these people may access information about you: _____'s doctors and other treatment providers who are involved in your care; health care providers who are covering or on call for _____ and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call _____ at _____ or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. Re-disclosure of Information. Any electronic health information about you may be re-disclosed by _____ _____; to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. Effective Period. This Consent Form will remain in effect until 3 years after the last date you received any services from _____ or until the day you withdraw your consent, whichever comes first.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to _____. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling _____ at _____. Note: Organizations that access your health information through _____ while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. Copy of Form. You are entitled to receive a copy of this Consent Form after you sign it.

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: Catholic Charities Family and Community Services

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at **www.RochesterRHIO.org**.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at **www.RochesterRHIO.org** or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: _____; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.