



Ryther
Child Center

Welcome to Ryther Child Center!

We will be in contact with you regarding the status of your application. You may also call the CD Admissions Coordinator at **(206) 517-0249** if you have any questions. We must have all of the required documents before we can consider your application. When a bed becomes available, we will contact you to schedule an appointment for admission. Please keep in mind that there may be a wait, due to the limited availability of treatment beds.

The admission process will take approximately three (3) hours. Parents/guardians should plan on being here for the entire time. In order to make the admission process as easy as possible, we have listed below the things that you **must** bring on the day of admission:

1. **At least a 30-day supply of currently prescribed medications in bubble-pack, not bottle, form, clearly labeled with the patient's name and prescription information.** If this is not done, your child will not be admitted at the scheduled time.
2. **Your medical insurance card** (whether or not treatment will be covered by insurance) and/or **your current DSHS medical coupon.**
3. A doctor's note for **any** over-the-counter medications taken regularly, even Aspirin or vitamins.

If you have any questions about these items or anything else, please feel free to call the CD Admissions Coordinator at **(206) 517-0249**.

Assessment/Intake Requirements

THOROUGH COMPLETION OF THE ATTACHED APPLICATION WILL EXPEDITE THE ADMISSION.

To apply for admission to Ryther Child Center's Adolescent Inpatient Chemical Dependency Program, the following items must be sent to the CD Admissions Coordinator:

Ryther Child Center application packet:

- 1. The attached Application
- 2. Patient Financial Data Form
- 3. Discharge Arrangements Form
- 4. Medication Form

Documentation of chemical dependency problems:

- 1. A copy of a chemical dependency assessment from within the last six months
- 2. Discharge summary for any recent drug and alcohol treatment from within the last year, either inpatient or outpatient

****The assessment or discharge summary must recommend Level II Inpatient or ASAM Level III.5**

Documentation of any mental health or learning issues:

- 1. Discharge summary for any recent mental health hospitalization
- 2. Copies of any recent mental health evaluations, and/or psychological testing reports
- 3. IEP (Individualized Education Program), including any testing or evaluation

Physical Health:

- 1. All applicants **MUST** have a physical examination performed within the last six (6) months and signed by a health care professional.
- 2. All applicants **MUST** have a tuberculosis (TB) test performed within the last six (6) months and signed by a health care professional. If the TB test results are positive, you must call the CD Admissions Coordinator at **(206) 517-0249** before admission.
- 3. Childhood immunization records (may possibly be obtained from last school attended)

Financial:

- 1. A copy of insurance card (front and back) and/or medical coupon
- 2. Proof of income (e.g., last year's tax return, last 2 months of paycheck stubs, or proof of unemployment)

Legal:

- 1. Court orders, At Risk Youth petitions, etc.
- 2. Legal custody documents, if applicable

Ryther's Address:

**Ryther Child Center, CD Admissions
2400 NE 95th St.
Seattle, WA 98115**

Ryther's Fax:

**(206) 525-9795
Attn: CD Admissions**

RYTHER CHILD CENTER
APPLICATION PACKET: ADOLESCENT INPATIENT CHEMICAL DEPENDENCY PROGRAM

PATIENT INFORMATION:

SS# _____ / _____ / _____

- Name _____
Last First Middle Other names used
- Gender: Female Male Transgender Other Unknown
- Age _____ D.O.B. _____ Race/Ethnicity _____
- If Hispanic, check one of the following:
 Puerto Rican Mexican Cuban Other Spanish/Hispanic Refused to Answer
- Other languages spoken/cultural practices _____
Is an interpreter needed for the patient? Yes No For family member(s)? Yes No
- Patient's address _____
Street City County State Zip
- Patient's Phone # (____) _____
- Who patient lives with _____ # of people in household _____

LEGAL GUARDIAN(S):

- Name _____ Relationship to Patient _____
- Address (if different from patient address) _____
Street City State Zip
- Home Phone # (____) _____ Work Phone # (____) _____
Cell Phone # (____) _____

What is the parent's/guardian's primary means of transportation? _____

EMERGENCY CONTACT: _____

(Person who can always contact parent/guardian)

- Home Phone # (____) _____ Work Phone # (____) _____
- Relationship to Patient _____

REFERRAL SOURCE: _____

(Agency and/or individual name)

Phone # (____) _____

Fax # (____) _____

RYTHER CHILD CENTER
APPLICATION PACKET: ADOLESCENT INPATIENT CHEMICAL DEPENDENCY PROGRAM

DIMENSION 1

SUBSTANCE USE HISTORY – Note: A current (within 6 months) drug & alcohol assessment for the patient (or a recent discharge summary) must accompany this application.

HAS PATIENT EVER USED THE FOLLOWING, EVEN ONCE, TO GET HIGH:

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Rx Medications_____ |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Opiates (Percodan, Vicodin, etc.) <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Marijuana <input type="checkbox"/> Ritalin/Dexedrine |
| <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Heroin <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Inhalants | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> PCP (Sherm, Angel Dust, “Wet”) <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Over the counter meds_____ | | |
| <input type="checkbox"/> Other and unknown (explain)_____ | | |

Patient’s Drug of Choice_____

Drug(s) used most in past 3-6 months_____

Has the patient ever had a drug overdose? Yes No

When_____ What drug(s)_____

What happened?_____

Current pattern of use (last 3-6 months of using – what substances, frequency and quantities)_____

Current crisis (what is prompting this application for treatment?)_____

SIGNIFICANT HIGH-RISK BEHAVIORS: please mark all patient symptoms observed		
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Illegal behavior to get \$ for drugs	<input type="checkbox"/> Suicidal thoughts/gestures
<input type="checkbox"/> Accidents while intoxicated	<input type="checkbox"/> Using needles to inject drugs	<input type="checkbox"/> Seizures (alcohol/drug related)
<input type="checkbox"/> Violence while intoxicated	<input type="checkbox"/> Arrests for DUI/MIP/MIC	<input type="checkbox"/> Daily use

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DIMENSION 2

Physician's Name _____ Phone number _____

Dentist's Name _____ Phone number _____

- Any current medical issues? Yes No

If yes, explain _____

- Currently under care for infectious disease Yes No In need
 - Currently under care for traumatic injury Yes No In need
 - Currently under care for continuing illness Yes No In need
 - Special dietary needs? (e.g., vegetarian) Yes No Explain _____
 - Any allergies? Yes No To what? _____
- If yes, any special precautions needed? Yes No
- If yes to either of the above, describe most severe allergic reaction _____

- Is patient currently taking medication? Yes No If yes, list type, dose, and reason for taking _____

Note: Ryther prohibits the use of certain medications (stimulants, such as Ritalin, and sedatives, such as Trazodone) while patients are in treatment. Please contact the Ryther CD Admissions Coordinator and your prescribing doctor for their recommendations.

- Does the patient currently need dental care? Yes No Explain _____
- Does the patient currently need vision care? Yes No Explain _____

If female:

- Does patient think she is pregnant? Yes No (If yes, please provide proof of having seen a physician for prenatal care)

DISABILITY - MAJOR LIMITATIONS (check all that apply)

- None Mobility Hearing Learning
 Vision Mental/Psychological Speech-Impaired Developmental

Other _____

- Does the patient consider him/herself to be disabled or have a handicap? Yes No
- If yes, are any accommodations needed? Yes No Describe _____

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DIMENSION 3

Has the patient ever had a psychiatric exam/evaluation? Y N
Diagnosis _____ By whom _____
Where (agency name) _____ When _____

(If exam was within the past 1 year, then a copy of the exam is required for admission)

Has the patient ever been hospitalized for psychiatric reasons? Y N
Where (agency) _____ When _____
Why _____

(If hospitalized within past 1 year, OR if patient has had 3 or more lifetime hospitalizations, then a copy of the most recent discharge summary is required for admission)

Is the patient currently receiving mental health services (within the past year)? Y N
Where (agency name) _____
Counselor Name _____ Phone # _____

Has the patient ever been placed on medication for psychiatric reasons? Y N
Where (agency name) _____ What med(s) _____
Prescribed by whom _____ When/how long ago _____

Is the patient currently on medication for psychiatric reasons? Y N
If yes, please fill out Chemical Dependency Inpatient Application Medication Form.

Note: Ryther prohibits the use of certain medications (stimulants, such as Ritalin, and sedatives, such as Trazodone) while patients are in treatment. Please contact the Ryther CD Admissions Coordinator and your prescribing doctor for their recommendations.

Has the patient ever attempted suicide? Y N How many times? _____
When (most recent) _____ How (method) _____

Was the patient using drugs or alcohol at the time of the attempt? Y N

Is the patient suicidal now? Y N

Describe any treatment the patient may have received for suicidality _____

Has the patient done any self-harm? Y N How many times? _____
When (most recent) _____ How (method) _____

How severe (describe) _____

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DIMENSION 3 (continued)

Does patient have an eating disorder or difficulties eating? Y N

When (most recent) _____ Describe _____

Describe any treatment the patient may have received for eating disorders _____

Has patient had violent, assaultive, or predatory sexual behavior? Y N

When (most recent) _____ Describe _____

Please describe any other recent psychiatric symptoms or unusual problem behaviors (e.g., destroying property, inappropriate sexual acting out, psychosis, severe problems relating to others, etc.)

DIMENSION 4

Does the patient feel he/she has a problem with drugs/alcohol? Yes No Please explain: _____

Does the patient feel he/she needs treatment? Yes No Please explain: _____

Is the patient willing to enter treatment? Yes No Unknown

Has the patient ever run away from home? Yes No

How many times? _____ When (most recent) _____ For how long _____

LEGAL:

• **Does the patient:**

Have a DUI Yes No Have a warrant Yes No

• Current/most recent charges _____

In what county/counties? _____ Date of last arrest _____

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DIMENSION 4 (continued)

CURRENT INVOLVEMENT WITH CRIMINAL JUSTICE SYSTEM (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> CHINS petition (Child In Need of Services) |
| <input type="checkbox"/> On Probation or Parole | <input type="checkbox"/> ARY petition (At-Risk Youth) |
| <input type="checkbox"/> CDDA Local Sanctioned | <input type="checkbox"/> In other supervised program (e.g., Drug Court) |
| <input type="checkbox"/> CDDA Committable | |

Is the patient facing time in detention or jail if he/she does not complete treatment? Yes No
 If yes, how long? _____

PREVIOUS ARREST(S) (Check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Drug Offenses | <input type="checkbox"/> Sexual offenses (whether charged or not) |
| <input type="checkbox"/> Violent offenses (assault, use of weapon) | <input type="checkbox"/> None |
| <input type="checkbox"/> Crime(s) Unknown | |

Probation/Parole Officer: _____ Phone # _____
 Cell phone # _____

DIMENSION 5

Has the patient ever received drug/alcohol treatment before (including detox)? Yes No

Program Name & Level (e.g., Intensive Outpatient)	Dates of Treatment	Treatment Completed	Time abstinent
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Detox admits:			

If the patient ended treatment without completing, describe reason(s) for leaving treatment _____

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DIMENSION 6

SCHOOL INFORMATION:

Is patient currently enrolled in school? (Or, if summertime, was the patient enrolled at the end of the previous school year?) Yes No

If not, date last attended _____ Current grade level _____

Current or last school attended _____ City located _____

• Ever been suspended or expelled Yes No If yes, why _____

• Has patient ever been involved in special education? Yes No

If yes, how many hours per day? _____

• Does patient have a current IEP? Yes No

If yes, what school/district/agency did the assessment? _____

• Does patient have memory problems? Yes No

• Does patient have difficulty with reading? Yes No

• Does patient have difficulty with writing? Yes No

FAMILY/ENVIRONMENT:

Who does the patient currently live with? _____

Is the patient expected to return to this same living arrangement after treatment? Yes No

If not, where is the patient expected to go? _____

Has there been recent use of drugs in the home by other family/household members, including alcohol and tobacco? Explain _____

Is the patient's home environment supportive of recovery (including both the immediate household and the neighborhood)? Explain _____

Can the parent(s)/guardian(s) participate in treatment? If so, how often? _____

Other support people who may be involved in the treatment process:

Name(s) _____ Relationship to patient _____

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DIMENSION 6 (continued)

Does the patient have any children of his/her own? Yes No If yes, please give age(s) and describe current living and/or custodial arrangements_____

Does the patient have any protection orders or no-contact orders with anyone? Yes No (If yes, additional information may be required at intake, such as a physical description of the other person or persons.)

Describe the patient's current and/or past involvement with gangs, if any_____

Any other information in support of this application for Inpatient Treatment_____

Name of person completing application Date Relationship to patient

Telephone Number

Names of other people contributing information on this application _____

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Parent/Guardian Questionnaire

Note: This form is to be filled out by the patient’s **parent, guardian, or other family support person**. If no such person is available, it is not necessary to fill out this form in detail.

At Ryther, we believe that teenagers do better in treatment when parents/guardians are involved. We want to understand how you, and other important adults, expect to be involved while your child is in the Ryther program.

In the table below, please list important **adults** in your child’s life, and indicate whether or not you expect each one to be involved with your child’s treatment. Also, please describe that person’s work schedule, if known (e.g., “Monday-Friday, 8:00 – 5:00,” or “Variable”).

	Involved in treatment?	Work outside the home?	Work Schedule (describe)
Mother (give name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Father (give name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stepmother (give name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stepfather (give name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (give name and relationship to patient)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (give name and relationship to patient)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Will any of the above people have issues that would prevent them from participating in the child’s treatment? If so, describe (e.g., unreliable car, can’t get time off from work, or living too far away):

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Parent/Guardian Questionnaire

We want to understand how you feel about your child's current situation and your expectations for the treatment process.

1. Briefly, how has your child's drug/alcohol use affected you and the rest of the family?

2. Do you want and/or expect your child to return home to live with you after treatment?
 Yes No Maybe

If **yes**, what changes need to happen at home to help insure that your child remains clean and sober after coming home? If **no**, do you have some ideas where he or she could live after leaving treatment?

3. What primary productive activity will your child be returning to once they come home (e.g., school, work, job-hunting, etc.)? (Please include any summertime activities, if appropriate.)

4. Our expectation is that families will participate in the Ryther Child Center family program at least once per week. Will you be able to participate at this level while your child is in treatment? If not, please explain briefly.

5. Are you aware of any changes that you, as a parent/guardian, need to make to help insure your child's sobriety? If so, please describe. (Examples might include stopping your own use of alcohol or other drugs, improving your parenting skills, taking anger management classes, etc.)

6. Are you familiar with Alcoholics Anonymous, Al-Anon, or any other self-help groups? Please describe.

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Parent/Guardian Questionnaire

DEVELOPMENTAL HISTORY

Please report any of the following physical, medical, behavioral, or emotional experiences that the patient may have experienced in his/her life. Check all that apply.

- Major problems with prenatal care or pregnancy
- Family disruption (death, divorce) (give age(s) of child at the time_____)
- Unstable home life (frequent moves, several remarriages, etc.)
- Major physical injury or illness (age_____)
- Head injury/concussion (age_____)
- Hyperactivity
- Known or suspected Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effect (FAE), or other prenatal exposure to drugs (please circle those which apply)
- Diagnosed learning disability (please include testing and special instruction information from school with this application)
- Victim of physical or sexual abuse (give age, or age range, when abuse occurred_____)
- Violence (by the patient) toward family members (age as of last incident_____)
- Violence (by the patient) toward people outside the family (age as of last incident_____)
- Interest in cults/gangs/unusual rituals
- Other traumatic experience (specify)_____

MEDICAL HISTORY

Has your adolescent ever received medication on a regular basis? If so, what was it called and why was it prescribed?

Describe briefly what food your adolescent likes to eat and the food he/she dislikes. Also, describe eating habits, including any diets he/she has been on. Has he/she ever had an eating disorder?

Please list any known allergies of your adolescent, including food and medications such as penicillin, strawberries, etc.

**RYTHER CHILD CENTER
APPLICATION PACKET: ADOLESCENT INPATIENT CHEMICAL DEPENDENCY PROGRAM**

Parent/Guardian Questionnaire

DEVELOPMENTAL HISTORY, continued

Has the patient ever engaged in behavior that resulted in a pregnancy? Yes No
If yes, how old was the patient at the time, and what was the outcome of the pregnancy?

Please indicate areas of strength for your adolescent. Check all that apply.

- Intelligent
- Learning, does (or did) well in school environment
- Relationships (makes friends easily, gets along)
- Sports, athletics
- Creative
- Talents, skills (e.g., music, art, mechanics)
- Positive personal qualities (e.g., caring, compassionate)
- Leadership skills
- Motivated, determined, faces up to things
- Honest
- Attractive
- Other (specify) _____

What other resources have you used to deal with your adolescent's problems?

	<u>Check if ever involved</u>	<u>Check if drug related</u>
Individual counseling	_____	_____
Family counseling	_____	_____
Group counseling	_____	_____
School counseling	_____	_____
Group home or residential treatment center	_____	_____
Hospitalization	_____	_____
Support group of AA/NA	_____	_____
Special education/alternate school	_____	_____
DSHS	_____	_____
Juvenile court	_____	_____
Church/Temple/Mosque	_____	_____
Other (specify)	_____	_____

Name of person filling out Parent/Guardian Questionnaire: _____

Relationship to patient: _____

Date: _____

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EARLY DISCHARGE ARRANGEMENTS AGREEMENT

Client Name: _____ Client ID #: _____

Parents/Legal Guardians are expected to be responsible for their children in the event their child is discharged from treatment.

Ryther Child Center is not required to maintain your child in placement for any length of time once it is determined that a discharge is necessary. By signing this form, you are agreeing to this condition and understand that this may mean picking up your child at any day or time of the week.

Initial

_____ I agree to pick up my child from treatment **on any day at any time** if she/he is discharged from treatment.

Only complete the next section if it is impossible for the parent/legal guardian to meet the above-mentioned responsibility. Alternative arrangements MUST be pre-approved by Ryther.

Please explain why the parent/legal guardian cannot pick up the client in the case of a discharge, and specify the alternate contact person(s) below:

Please state the name of the adult who will meet this responsibility:

Name Relationship to Client

Home Phone Work Phone Other Phone

Please initial below that you agree to be responsible for picking up the client from treatment **on any day at any time** if she/he is discharged.

_____ I agree to pick up _____ from treatment **on any day at any time** if she/he is discharged.

I understand that if I refuse to pick up this child in the event of a discharge, that Ryther will notify CPS of an abandoned child and will report me.

Parent/Legal Guardian Signature Date

Home Phone Work Phone Emergency Phone

Program Staff Signature Date

Chemical Dependency Inpatient Application
MEDICATION FORM

If the applicant is taking any medication on a regular basis, please fill out this form.

Please remember:

- All prescription medications (that are in pill form) must be bubble-packed by the pharmacy and have the prescription label on it with the name and phone number of the prescribing doctor and be made out in the applicant's name.
- A 30-day supply of each prescription is required upon admission.
- If the medication is not bubble-packed, it will be the family's responsibility to have this done at a local pharmacy before the client will be admitted.
- Please review the following page for prohibited medications.
- Ryther Child Center will provide all needed over-the-counter medications. If the applicant is taking any over-the-counter medications on a routine basis, a doctor's note explaining why this is necessary is needed, along with a 30-day supply of this medication.

1. What prescription medications is the applicant currently prescribed?

2. Who is the prescribing doctor, and what is their contact information?

3. If the applicant is no longer taking the prescribed medications, how long has it been since last use; why did the applicant stop using the prescribed medication?

4. Does the prescribing doctor know that the applicant is no longer taking the prescribed medication? If not, please provide confirmation that the prescribing doctor is aware that the applicant is no longer taking the medications, and any related instructions.

Client Name _____

RCC # _____

RYTHER CHILD CENTER

Prohibited Medications for Chemical Dependency Inpatient

Stimulants:

may be considered under some circumstances

Ritalin (methylphenidate, Methylin, Metadate, Concerta, Focalin)

Adderall (amphetamine salts, Adderall XR)

Dexedrine (dextroamphetamine, Dextrostat)

*Phentermine, Ionamin, Phentride, Phentercot, Tenormin, Adipex, Pro-fast *rare

Usually anorectics: Meridia (sibutramine)

Anxiolytics/Sedatives:

Librium (chloridiazepoxide)

ProSom (estazolam)

Klonopin (clonazepam)

Ativan (lorazepam)

Tranxene (chlorazepate)

Restoril (temazepam)

Valium (diazepam)

Xanax (alprazolam)

Dalmane (flurazepam)

Serax (oxazepam)

Halcion (triazolam)

*Vistaril, Atarax (hydroxyzine), and
Benadryl (diphenhydramine),
unless for allergic reaction

*Limbitrol (combination of Librium
and amitriptyline)-unusual

Sonata, Starnoc (zaleplon)

Chloral hydrate

Ambien (zolpidem)

Trazodone

Seroquel (quetiapine), if only for sleep.

Doxepin (sinequan), if only for sleep.

Drug Dependence Treatment:

Antabuse (disulfiram)

Methadone (dolphine, methadose)

Naltrexone (ReVia, depade) *rarely, can be used to treat self-harm behaviors

Nicotine (any form, ex: cigarettes, gum, patch, spray)

Wellbutrin (Zyban, bupropion), if used for smoking cessation

Muscle Relaxants:

Baclofen (lioresal)

Soma (carisoprodal)

Chlorzoxazone (paraflex, parafon forte, remular)

Flexeril (cyclobenzaprine)

Skelaxin (metaxalone)

Methocarbamol (Robaxin)

Norflex (orphenadrine)

Esgic, Fioricet, Fiorinal, Norgesic, Robaxisol, Ultracet

Painkillers:

Any, except Tylenol, Ibuprofen, Naproxen

Cough Syrups: most

Residential C/D Inpatient C/D Outpatient Mental Health OP ECFS

RYTHER CHILD CENTER Patient Financial Data

Child/Adolescent Information:

Name: _____ Age: _____ DOB: _____
Last First Middle

What is your gender? (Circle one) Female Male Transgender Other Unknown

Are you non-English speaking or of limited English ability? (Circle one) Yes No

Are you an immigrant, refugee, or new arrival to the United States? (Circle one) Yes No

Do you consider yourself to be disabled or to have a handicap? (Circle one) Yes No

SSN: _____ Race/Ethnic Origin: _____ County of residence: _____

Address: _____
Street Address City State Zip

EMERGENCY CONTACT: _____ PHONE #: _____

Relationship to Child/Adolescent: _____

Parent/Guardian Information:

Parent/Guardian Name: _____ DOB: _____
Last First M.I.

Relation to Patient: _____ SSN: _____ Drivers License # _____

Address: _____ Phone #: _____
Street

_____ County of residence: _____
City State Zip

Years at residence: _____ Rent Own Number of children at home: _____ Ages: _____
Marital Status: Married Single Separated Divorced Widowed

Employer: _____ Phone #: _____

Address: _____
Street Address City State Zip

Length of employment: _____ Position: _____ Department: _____

Spouse's Name: _____ DOB: _____
Last First M.I.

Relation to Patient: _____ SSN: _____ Drivers License # _____

Employer: _____ Phone #: _____

Address: _____
Street Address City State Zip

Length of employment: _____ Position: _____ Department: _____

DSHS Caseworker (If applicable): _____ Phone #: _____

Address: _____

Patient's Name: _____

Child/Adolescent Medical Coverage:

Insurance Company Name: _____ Phone #: _____

Policyholder Name: _____ Relation to Patient: _____

Group name: _____ Group #: _____

Policy #: _____ Policy holder SSN: _____

Primary Physician: _____ Phone #: _____

Is Child/Adolescent enrolled in a Community Mental Health Center? No Yes Don't Know

Contact Person: _____ Phone #: _____

Does child/adolescent have medical coupons? No Yes - Please submit a copy of card.

Public Assistance Case #: _____ PIC #/Code: _____

Type of Public Assistance: _____

Parent / Guardian Household Income Information:

Household Gross Monthly Income (before taxes): Salary (Gross monthly) \$ _____

Public Assistance _____

Alimony/Child Support _____

Income from Rental Property _____

Other Monthly Income _____

Total Gross Monthly Income \$ _____

Household Gross Yearly Income \$ _____

I, the undersigned, verify that the information provided above is accurate and complete to the best of my knowledge.

X _____
Signature Date

I further authorize Ryther Child Center to contact my employer to obtain verification of current salary, length of employment with this employer, and employee status (full-time, part-time, hourly, etc.).

X _____
Signature Date

Office Use Only

Obtain at least one of the following: ● Last tax return ● Copy of current pay document ● Bank/other expense verification for last 2 months

Disposition

Information Only

Referred

To: _____

Assessment set

Date/Time: _____

Admission set

Date/Time: _____

Financial intake notified

Date/Time: _____