Red River Therapeutic Solutions
Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Patient Label if Applicable

Recipient Contact Information:

Name: ____

Address: ______________________ City: ________________ Zip: __________

Home Phone: __________________ Cell: __________ Other Phone: __________

Behaviors of Concern:

SCHOOL:

- ☐ Out of school/refuses to attend
- ☐ Harm or serious threat to staff
- ☐ Disruptive/Hyperactive
- ☐ Failing all or most classes
- ☐ Noncompliant/Refuses to follow rules requested from authority
- ☐ Violent (fighting, bullying, etc.) to staff/peers
- ☐ Victim of bullying (cyber/internet, face-to-face, etc.)
- ☐ Must have special accommodation(s) to maintain behavior in class
- ☐ No friends/peer relationships
- ☐ Crying spells
- ☐ Disrespect to adults/parents/teachers

HOME:

- ☐ Taken out of/or at risk of removal
- ☐ Needs close supervision to stay in home
- ☐ Isolates/Withdrawn
- ☐ Serious threat of harm or intimidation
- ☐ Disregards rules/curfew/out of control
- ☐ Major changes in home
- ☐ Severe damage to property
- ☐ Behavior interferes with parent/guardian's work
- ☐ Changes in mood
- ☐ Enuresis
- ☐ Encopresis
- ☐ Nightmares
- ☐ Crying spells

COMMUNITY:

- ☐ Incarcerated due to serious law violation
- ☐ Has committed serious property damage
- ☐ Been arrested
- ☐ Serious/repeated delinquent behavior
- ☐ On probation for offense within the last 3 months
- ☐ Plays with fire
- ☐ Violent offense

Other Reason for Referral:

Referral source (if other than self) :

Name of Person/Agency: ______________________________________

Address: ______________________ Phone: ____________________

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Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Patient Label if Applicable

Admission Form

Date of Admission: ________________

Recipient Name: ____ **SSN:** ________________

Medicaid #: __________________________ **Insurance Provider:** ___________________________

Recipient Contact Information:

Recipient Contact Information:

Address: __________________________________ City: _______________________ Zip: ___________

Home Phone: __________________________ Cell: _______________ Other Phone: _______________

Parent/ Legal Guardian Information:

Name: ____ Relationship: _________________________

Address: __________________________________ City: _______________________ Zip: ___________

Home Phone: __________________________ Cell: _______________ Other Phone: _______________

Medical Contact Information:

Primary Care Physician: __________________________________

Address and Phone: _____________________________________

Medical Conditions or Allergies:	Yes	No
Use of medications or assertive devices?	Yes	No
Is there a need for assistive technology in providing services?	Yes	No

If you answered YES to any of the above questions, describe on the back

Date of Birth: ___________________ **Age at Admit:** _______ **Sex: M F**

Race: 1-White **2**-Black/African American **3**-Asian/Pacific **4**-Indian **5**-Alaskan **6**-Other

Ethnicity: 1-NonHispanic **2**-Hispanic

Education: Last grade completed: ________ Current School: _______________________________

Household Comp: 1-Adult Only **2**-Adult with relative **3**-Adult with non-relative **4**-Child with both parents **5**-Child with one parent **6**-Child with relative **7**-Child living in foster family

____ ______________________________
Recipient's Signature Date

____ ______________________________
Parent/Guardian's Signature Date

____ ______________________________
Staff Witness Signature Date

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Red River Therapeutic Solutions
Mental Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office
(318) 220-8573 FAX

Consent to Treatment

- I, ___________________________, give permission for Red River Therapeutic Solutions to give me
  Client Name

behavioral health treatment. I consent to abide by the Agency's specific policies and procedures relating to services that have been reviewed with me, which include provisions for termination of services at request by me, the physician, or the Agency.

- I allow Red River Therapeutic Solutions to file for insurance benefits to pay for the care I receive. I request the payment of authorized benefits be made to Red River Therapeutic Solutions on my behalf.
- I understand that:

  Red River Therapeutic Solutions will have to send my medical record information to my insurance company and authorized external review agencies to verify eligibility, confirm benefits, or pay claims. I authorize my records to be reviewed for any necessary audits or accrediting surveys by representatives of CARF, DHH, and/ or state agencies. I understand that no limitations are placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse, psychiatric/ psychosocial information and AIDS related information. I understand this can be revoked at any time by written request except that disclosure has already occurred in reliance on this consent.
- I understand that:
  - I have the right to refuse any procedure or treatment.
  - I have the right to discuss all medical treatments with my provider.
- I understand that I will receive some or all of the following services:
  - Community Psychiatric Support and Treatment (CPST)
  - Psychosocial Rehabilitation (PSR)
  - Individual Counseling
  - Crisis Intervention
  - Medication Management
- I acknowledge receipt of Red River Therapeutic Solutions' handbook, which includes Rights and Responsibilities. The contents have been explained to me and I understand the meaning. I have participated in the care planning process and agree to all the above.
- I acknowledge that a representative of Red River Therapeutic Solutions has discussed the following elements prior to the receipt of telemedicine/telehealth services and I am authorizing the services:
  - The rationale for using telemedicine/telehealth in place of in-person services.
  - The risks and benefits of the telemedicine/telehealth, including privacy-related risks.
  - Possible treatment alternatives and those risks and benefits.
  - The risks and benefits of no treatment.

_______________________________ ________________
Signature of parent or guardian Date

_______________________________ ________________
Signature of RRTS Staff Date

Red River Therapeutic Solutions
Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Patient Label if Applicable

INDEMNIFICATION, HOLD HARMLESS

AND RELEASE AGREEMENT

The undersigned, ______________________________, a recipient of Mental Health Services (hereinafter referred to as "MHS") through **Red River Therapeutic Solutions**, hereby indemnifies and holds harmless Red River Therapeutic Solutions, its personnel and any and all related corporate entities which may be affiliated with the provider of said MHS services. This indemnity and hold harmless agreement shall release Red River Therapeutic Solutions and any of its affiliates from any claims of any kind whatsoever or of any nature for injury to the person or his/her parents or siblings or any individual claiming damages in association with MHS services. This indemnity and hold harmless agreement shall be considered a complete and total waiver of any and all liability on the part of Red River Therapeutic Solutions, and any corporate entity or person associated with same.

______________________________ ______________________

Recipient's Signature Date

______________________________ ______________________

Parent/Guardian's Signature Date

______________________________ ______________________

Staff Witness Signature Date

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Red River Therapeutic Solutions
Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Patient Label if Applicable

Consent To Obtain, Release And/or Share Information
Medical Records

Name: ________________________ **Phone:** ________________

Address: ____

SSN: ____________________ **DOB:** ________________

This is a request to have my protected health information _____ **released to** or _____**obtained from** a third party. Specifically, I am requesting that the agency listed below forward the indicated information.

Agency Name: ______________________ **Address:** ________________
Phone: ______________________ **Fax:** ________________

□ Discharge Summary □History and Physical Exam □Psychiatric Evaluation
□Medication History □Social History □ H.I.V. Information
□Drug and Alcohol Information □ Other Information ____________

Purpose of Disclosure: ____

Please mail or fax the requested medical records to:

Name: Red River Therapeutic Solutions
Address: 2715 Mackey Place Ste 135 Shreveport, LA 71118
Phone: (318) 220-8423 FAX: (318) 220-8573

I understand that the information released is for professional purposes only and may not be provided in whole or part to any other agency or person other that the one listed above. This consent may be revoked in writing at any time, except when action has already been taken. Under those circumstances, the consent will expire upon completion of the transaction. This authorization expires 365 days from the date of signature unless otherwise stated.

Federal law prohibits the receiving party of this confidential information to further disclose without the consent of the Recipient or parent/ guardian to whom it pertains.

Please understand that failure to sign and authorize for release of information for purposes other than treatment, payment, or operations will not impact health care provided. I acknowledge and give consent for this information to be released via facsimile transmission or mail.

______________________ ______________
Recipient's Signature Date

______________________ ______________
Parent/Guardian's Signature Date

______________________ ______________
Staff Witness Signature Date

Rev. 4/2019

Red River Therapeutic Solutions
Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Patient Label if Applicable

Consent To Obtain, Release And/or Share Information
Educational Information and Access to Student

Name: ______________________ **Phone:** ______________________

Address: ____

SSN: ______________________ **DOB:** ______________________

This is a request to have my protected health information _____ **released to** or _____**obtained from** a third party. Specifically, I am requesting that the agency listed below forward the indicated information.

Name of School: ______________________ **Address:** ______________________

Phone: ______________________ **Fax:** ______________________

- ☐ Attendance
- ☐ Social History
- ☐ Discharge Summary
- ☐ Quarterly Reports
- ☐ Individual Educational Plan (IEP)
- ☐ Special Educating Info (504)
- ☐ Medication History
- ☐ Schedule of Classes
- ☐ Psychological Testing Results
- ☐ Standardized Testing Results
- ☐ Psychiatric Evaluation
- ☐ Other Information ______________

Purpose of Disclosure: ____

Please mail or fax the requested medical records to:

Name: Red River Therapeutic Solutions
Address: 2715 Mackey Place Ste 135 Shreveport, LA 71118
Phone: (318) 220-8423 FAX: (318) 220-8573

I understand that the information released is for professional purposes only and may not be provided in whole or part to any other agency or person other that the one listed above. This consent may be revoked in writing at any time, except when action has already been taken. Under those circumstances, the consent will expire upon completion of the transaction. This authorization expires 365 days from the date of signature unless otherwise stated.

Federal law prohibits the receiving party of this confidential information to further disclose without the consent of the Recipient or parent/ guardian to whom it pertains.

Please understand that failure to sign and authorize for release of information for purposes other than treatment, payment, or operations will not impact health care provided. I acknowledge and give consent for this information to be released via facsimile transmission or mail.

______________________ ______________
Recipient's Signature Date

______________________ ______________
Parent/Guardian's Signature Date

______________________ ______________
Staff Witness Signature Date

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Red River Therapeutic Solutions
Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Patient Label if Applicable

Consent To Obtain, Release And/or Share Information
Emergency Contact

Name: ______________________ **Phone:** ______________________

Address: ______________________

SSN: ______________________ **DOB:** ______________________

This is a request to have my protected health information _____ **released to** or _____**obtained from** a third party. Specifically, I am requesting that the agency listed below forward the indicated information.

Emergency Contact Name : ______________________ **Relationship:** ______________________
Address:______________________ **Phone:** ______________________

- ▫ Discharge Summary
- ▫History and Physical Exam
- ▫Date of Service Letter
- ▫Psychiatric Evaluation
- ▫ Laboratory/X-ray
- ▫Medication History
- ▫Social History
- ▫ H.I.V. Information
- ▫ Other Information
- ▫ Psychological
- ▫Drug and Alcohol Information
- ▫ Clinical Evaluation
- ▫ Integrated Summary
- ▫ Quarterly Reports

Purpose of Disclosure: ______________________

Please mail or fax the requested medical records to:

Name: Red River Therapeutic Solutions
Address: 2715 Mackey Place Ste 135 Shreveport, LA 71118
Phone: (318) 220-8423 FAX: (318) 220-8573

I understand that the information released is for professional purposes only and may not be provided in whole or part to any other agency or person other that the one listed above. This consent may be revoked in writing at any time, except when action has already been taken. Under those circumstances, the consent will expire upon completion of the transaction. This authorization expires 365 days from the date of signature unless otherwise stated.

Federal law prohibits the receiving party of this confidential information to further disclose without the consent of the Recipient or parent/ guardian to whom it pertains.

Please understand that failure to sign and authorize for release of information for purposes other than treatment, payment, or operations will not impact health care provided. I acknowledge and give consent for this information to be released via facsimile transmission or mail.

______________________ ______________________
Recipient's Signature Date

______________________ ______________________
Parent/Guardian's Signature Date

______________________ ______________________
Staff Witness Signature Date

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Behavioral Health Services
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Patient Label If Applicable

Media Release

Recipient Name: ____________________________

Red River Therapeutic Solutions, LLC may develop, participate in, or be the subject of media-based presentations and events, which highlight various activities that take place during the year.

1. Those developed by Red River Therapeutic Solutions, LLC and/or commercial enterprises. These may include but are not limited to:
   - Photographs of Recipients and activities
   - Slide/tape presentations
   - Videotapes of Recipients and families
   - Computer generated presentations which may incorporate scanned photographs and video clips
   - Computer based productions transmitted via telecommunications
2. These media-based presentations may be used in:
   - Staff in-services
   - Staff development activities
   - Public relations
   - Newspaper articles
   - TV presentations
   - Red River Therapeutic Solutions, LLC approved Internet web pages

Check ONE:

☐ I hereby **GIVE** my permission to **Red River Therapeutic Solutions, LLC** to publish my name, photograph, and comments (as listed above) in any of Red River Therapeutic Solutions, LLC media-based productions for the above stated purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization.

☐ I hereby **DENY** my permission to **Red River Therapeutic Solutions, LLC** to publish my name, photograph, and comments (as listed above) in any Red River Therapeutic Solutions, LLC media-based productions for the above stated purposes.

Recipient's Signature	Date
Parent/Guardian's Signature	Date
Staff Witness Signature	Date

Red River Therapeutic Solutions
Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Patient Label if Applicable

ORIENTATION CHECKLIST

The following information has been provided as part of the consumer orientation. A check of the item and the signatures below indicate that each area has been fully explained and is understood by the consumer.

- ❑ Rights and grievance and appeal procedures
- ❑ Services provided, days and hours of operation, expected level of participation
- ❑ Access to emergency services, after hours
- ❑ Code of ethics/conduct
- ❑ Confidentiality policy, limits of confidentiality
- ❑ Methods, opportunities, and policy on input
- ❑ Explanation of financial obligations, fees, and financial arrangements
- ❑ Fire, safety, and emergency precautions
- ❑ Policy on restraint
- ❑ Policy on tobacco products
- ❑ Policy on illicit or licit drugs brought into the program
- ❑ Policy on weapons brought into the program
- ❑ Policy on pets
- ❑ Identification of the person responsible for service coordination
- ❑ Program rules, including restrictions and the loss and regaining of rights
- ❑ Individual plan development
- ❑ Discharge/transition criteria and procedures

Recipient's Signature	Date
Parent/Guardian's Signature	Date
Staff Witness Signature	Date

Rev. 4/2019

Member Name (First, Last Name): Member DOB:
Member ID #:

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member Information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from one provider unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711
2. Amerihealth Caritas Louisiana: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call 1-888-756-0004; TTY 1-866-428-7588
3. Healthy Blue: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)
4. Louisiana Healthcare Connections: https://providersearch.louisianahealthconnect.com/ or call 1-866-595-8133 (Hearing Loss: 711)
5. United Healthcare Community: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514

The provider that I have freely selected to deliver MHR services to me or my child is:

Provider Name:	RED RIVER THERAPEUTIC SOLUTIONS
Provider Phone Number:	318-220-8423
Provider Contact Name:	
Provider Address:	2715 MACKEY PL STE 135 SHREVEPORT, LA 71118

By signing the form below, I understand that I have chosen to receive services from this MHR provider and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

Member/Legal Guardian Signature Date

Printed Legal Guardian Name (if applicable)

Providers Information: A Member Choice form is required prior to receiving any mental health rehabilitation services. . This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

Provider Signature Date

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member name:

Member ID number: Member date of birth:

Member information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from one provider unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: **www.aetnabetterhealth.com/louisiana/find-provider** or call **1-855-242-0802 (TTY/TDD 711).**
2. Amerihealth Caritas Louisiana: **www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx** or call **1-888-756-0004 (TTY 1-866-428-7588).**
3. Healthy Blue: **www.myhealthybluela.com/la/care/find-a-doctor.html** or call **1-844-227-8350 (TTY/TTD 711).**
4. Louisiana Healthcare Connections: **https://providersearch.louisianahealthconnect.com** or call **1-866-595-8133 (TTY/TTD 711).**
5. United Healthcare Community: **www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html** or call **1-866-675-1607 (TTY 1-877-4285-4514).**

The provider that I have freely selected to deliver MHR services to me or my child is:

Provider name: RED RIVER THERAPEUTIC SOLUTIONS

Provider phone number: 318-220-8423

Provider contact name:

Provider address: 2715 MACKEY PL STE 135 SHREVEPORT, LA 71118

By signing the form below, I understand that I have chosen to receive services from this MHR provider and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

Member/legal guardian signature: Date:

Printed legal guardian name (if applicable):

Provider's information: A Member Choice form is required prior to receiving any mental health rehabilitation services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

Provider signature: Date:

Mental Health Screening Form–III (MHSF–III)

Instructions: In this program, we help people with *all* their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency *without your permission.* If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your *entire life history, not* just your current situation. This is why each question begins, "Have you ever . . . "

Please circle "yes" or "no" for each question.

1. Have you *ever* talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? .... Yes No
2. Have you *ever* felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? .... Yes No
3. Have you *ever* been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? .... Yes No
4. Have you *ever* been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? .... Yes No
5. Have you *ever* heard voices no one else could hear or seen objects or things which others could not see? .... Yes No
6. (a) Have you *ever* been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? .... Yes No
   (b) Did you ever attempt to kill yourself? .... Yes No
7. Have you *ever* had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? .... Yes No
8. Have you *ever* experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? .... Yes No
9. Have you *ever* given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? .... Yes No
10. Have you *ever* felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? .... Yes No
11. Have you *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? .... Yes No
12. Was there *ever* a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? .... Yes No

continued on other side

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13. Have you *ever* had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? .... Yes No
14. Have you *ever* had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? .... Yes No
15. Have you *ever* had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. .... Yes No
16. Have you *ever* lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? .... Yes No
17. Have you *ever* been told by teachers, guidance counselors, or others that you have a special learning problem? .. .. Yes No

Print client's name: ______________________________

Program to which client will be assigned: ________________________

Name of admissions counselor: ____________________ Date: __________

Reviewer's comments: ______________________________

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: __________ Child's Name: ______________________________ Date of Birth: ____________

Parent's Name: ______________________________ Parent's Phone Number: ______________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ________ Child's Name: ______________________ Date of Birth: ____________

Parent's Name: ______________________ Parent's Phone Number: ______________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ____________

Total number of questions scored 2 or 3 in questions 10–18: ____________

Total Symptom Score for questions 1–18: ____________

Total number of questions scored 2 or 3 in questions 19–26: ____________

Total number of questions scored 2 or 3 in questions 27–40: ____________

Total number of questions scored 2 or 3 in questions 41–47: ____________

Total number of questions scored 4 or 5 in questions 48–55: ____________

Average Performance Score: ____________

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

Name: ______________________________ **Date:** ____________________

RISK ASSESSMENT

1. Risk of Harm to Self (Check all the boxes below by indicating either "yes" or "no")			
Behavior	**Yes/No**	**Behavior**	**Yes/No**
Prior suicide attempt	☐ No ☐ Yes	Repeated attempts, increase in severity	☐ No ☐ Yes
No repeated attempts and severity has decreased.	☐ No ☐ Yes	Stated plan and intent	☐ No ☐ Yes
Access to means (weapons, pills, etc)	☐ No ☐ Yes	Substance abuse history	☐ No ☐ Yes
Recent loss	☐ No ☐ Yes	Marked lack of support	☐ No ☐ Yes
Presence of behavioral clues (isolation, giving away possessions, rapid improvement in mood, etc)	☐ No ☐ Yes	Symptoms of psychoses with command hallucinations or paranoia	☐ No ☐ Yes
Family history of suicide	☐ No ☐ Yes	Suicide of friend or acquaintance	☐ No ☐ Yes
Terminal illness	☐ No ☐ Yes	Other:	☐ No ☐ Yes

2. Risk of Harm to Others (Check all the boxes below by indicating either "yes" or "no")			
Behavior	**Yes/No**	**Behavior**	**Yes/No**
Prior acts of violence	☐ No ☐ Yes	Fire setting	☐ No ☐ Yes
Destruction of property	☐ No ☐ Yes	Angry mood, agitation	☐ No ☐ Yes
Arrests for violence	☐ No ☐ Yes	Prior hospitalization for danger to others	☐ No ☐ Yes
Access to means (weapons)	☐ No ☐ Yes	Substance use (current/ past)	☐ No ☐ Yes
Harms animals	☐ No ☐ Yes	Symptoms of psychoses with command hallucinations or paranoia	☐ No ☐ Yes
History of being physically abused	☐ No ☐ Yes	Has been physically abusive to others	☐ No ☐ Yes
Recipient Safety and Other Risk Factors: (Check all the boxes below by indicating either "yes" or "no")			
Risks	**Yes/No**	**Risks**	**Yes/No**
Does the recipient feel unsafe in their current living environment?	☐ No ☐ Yes	Does the recipient report currently being harmed/hurt/abused/threatened by someone in any way?	☐ No ☐ Yes
Does the recipient report currently being touched inappropriately by anyone?	☐ No ☐ Yes	Does the recipient report ever report being harmed/hurt/abused/threatened in any way by someone in the past?	☐ No ☐ Yes
Does the recipient report ever being touched inappropriately by anyone in the past?	☐ No ☐ Yes	Does the recipient engage in any sexual behavior that might put them at risk for harm or legal involvement?	☐ No ☐ Yes
Does the recipient report anyone in their household/family ever being touched inappropriately by anyone in the past?	☐ No ☐ Yes	Does the recipient report anyone in their household/family ever being harmed/hurt/abused/threatened by someone in any way in the past?	☐ No ☐ Yes
Has the recipient or anyone in their household ever been involved with Child or Adult Protective Services?	☐ No ☐ Yes	Other risk:	☐ No ☐ Yes

Name: ______________________________ **Date:** ____________________

Other risk:	☐ No ☐ Yes	Other risk:	☐ No ☐ Yes

SUBSTANCE ASSESSMENT

Section I – Screening Questions

All recipients should complete Section I – Screening Questions. If a "Yes" is answered on one or more questions in Section I, the provider should ensure a more detailed substance abuse assessment is arranged.

1. Have you tried to hide that you were using alcohol, marijuana or other drugs? ☐ No ☐ Yes

2. Have your parents, family, partner, co-workers, classmates or friends complained about your alcohol, marijuana or other drug use? ☐ No ☐ Yes

3. Have you used alcohol, marijuana or other drugs weekly? ☐ No ☐Yes

4. Have you kept using alcohol, marijuana or other drugs even after you knew it could get you into fights or other kinds of legal trouble? ☐ No ☐ Yes

5. Have you spent a lot of time either getting alcohol, marijuana, or other drugs, using them or feeling the effects of them (high, sick)? ☐ No ☐ Yes

Disposition

____ No substance abuse issues indicated by answers to screening questions.

____ Additional substance abuse assessment indicated – person to be referred for further assessment.

Referred to: ____________________________ Date Referred: ______________

Contact Person for F/U: ____

Clinician Signature: ____________________________ Date: ______________

Red River Therapeutic Solutions
Behavioral Health Services
2715 Mackey Place Ste 135
Shreveport, LA 71118
(318) 220-8423 Office (318) 220-8573 Fax

Client Entrance Survey

Date__________

Please complete the following information prior to completing the survey.

Gender:
- ☐ Male
- ☐ Female
- ☐ Transgender

Age:
- ☐ 11 and under:
- ☐ 12-17
- ☐ 18-21
- ☐ 22-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 +

Race:
- ☐ African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Indian
- ☐ Arabic
- ☐ Other: ______________

Survey Was Completed With Help From:
- ☐ Help from No One
- ☐ Help from staff member
- ☐ Help with friend
- ☐ Help from Family Member

Revised 02/2019

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Client Entrance Survey cont.

Please circle the number under each item that represents your opinion

Survey Questions

1. I am satisfied with the referral process (locating treatment).

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

2. It was easy to find the facility.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

3. The staff did a good job in reference to customer service.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

4. I received feedback from staff regarding services quickly.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

5. All of my questions were answered during intake.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

6. I feel safe in the environment.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

7. I am likely to recommend your organization to someone needing services.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

8. I have been treated with dignity and respect.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

9. I am satisfied with program orientation.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

10. My expectations in reference to admission were fully met.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know

Please provide us with comments and feedback about this program

____
____
____
____
____

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Shreveport, LA 71118
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(318) 220-8573 FAX

My signature below acknowledges that I have received an individualized treatment plan.

______________________________ ______________________________

Recipient's Signature Date

______________________________ ______________________________

Parent/Guardian's Signature Date

______________________________ ______________________________

Licensed Mental Health Professional Signature Date

Revised 12/2019

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Shreveport, LA 71118
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My signature below acknowledges that I have received an updated individualized treatment plan.

______________________________	______________________________
Recipient's Signature	Date
______________________________	______________________________
Parent/Guardian's Signature	Date
______________________________	______________________________
Licensed Mental Health Professional Signature	Date