



CEDAR CREST CLINIC

Patient Name: _____

3106 S. WS YOUNG DR, STE B-201
KILLEEN, TX 76542
PH 254.519.4162
FAX 254-519-3464

PATIENT INFORMATION

Thank you for choosing our clinic. In order to serve you properly, we need the following information. Please print. All information is confidential.

PATIENT

Patient's Name: _____ Patient Soc Sec #: _____

Home address: _____
Street Address (Not a P.O. Box) City/State Zip Code

Home phone#: _____ Alternate phone #: _____

Patient's Marital Status: Married Single Divorced Minor Other _____

Male/Female Race _____ Religion _____ DOB _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home address: _____
Street Address (Not a P.O. Box) City/State Zip Code

Home phone#: _____ Work #: _____ Cell #: _____

FAMILY INFORMATION

Father's Name: _____ DOB: _____ Phone #: _____

Mother's Name: _____ DOB: _____ Phone #: _____

Guardian's Name: _____ DOB: _____ Phone #: _____

INSURANCE

Primary Insurance Company: _____

Name of Insured: _____ Relationship: _____ Insured DOB: _____

Insured SSN: _____ Home Phone#: _____ Cell #: _____

Insured's Employer: _____ Work Phone#: _____

Secondary Insurance Company: _____

Name of Insured: _____ Relationship: _____ Insured DOB: _____

Insured SSN: _____ Home Phone#: _____ Cell #: _____

Insured's Employer: _____ Work Phone#: _____

Completed by: _____ Date: _____



AUTHORIZATIONS & ASSIGNMENTS

AUTHORIZATION FOR CARE: I do hereby give permission and consent to Cedar Crest Clinic for the administration of any and all examinations, diagnostic procedures, and treatment determined by the provider of my choice. I understand the primary treatment procedures to be employed, major goals of such treatment, and alternative treatment options.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for the total charges of services rendered and I agree that all amounts are due and payable to the provider upon receipt of services.

CO-PAYMENTS: I understand that all co-payments must be paid at the time of my visit.

INSURANCE COVERAGE: I certify that the insurance reported today is a complete listing of all the insurance companies that provide coverage to the above-named patient. I understand that no claims can be made to any insurance not reported for this treatment.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION: I authorize Cedar Crest Clinic to disclose to my insurance carrier(s) any and all information or copies which may be necessary for payment of claim. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire with the payment of claim and after fulfillment of legal and/or contractual agreement with my insurance carrier(s). I also authorize Cedar Crest to contact the professional who referred me/my child to Cedar Crest Clinic, to complete a survey of the professional's satisfaction with our services.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Cedar Crest Clinic and to the provider for medical benefits specified and otherwise payable to me but not to exceed Cedar Crest's regular charges for this service provision. I understand that Cedar Crest files insurance as a courtesy to patients. I understand that should the insurance not pay within 60 days from the date of service, payment will be due in full from guarantor.

CANCELLATIONS: I understand that I must cancel an appointment at least 24 hours in advance. If a 24 hour notice is not given, I understand that I will be billed a cancellation fee of \$50.00.

PRESCRIPTION REFILLS: I understand that I must call at least 7 days before I need to have a prescription refilled. Clinic staff will set up a medication management appointment, which takes approximately 15 minutes. If I run out of medication, clinic physicians can only provide me with enough medication to last until I am scheduled for an appointment.

RETURNED CHECKS: There will be a \$30.00 charge for non-sufficient fund (NSF) checks. I understand that if my check is returned for NSFs, the clinic will no longer be able to accept checks from me. The clinic will accept payment by cash, money order, or credit card only.

CONFIDENTIALITY: I agree to respect the privacy of other patients and their families and will not disclose their names or confidential information outside the clinic office.

PHONE CALLS: I understand that it may take 24 hours for the provider to return phone calls, unless the situation is deemed to be an emergency.

I have read, understand, and agree to the above.

Patient and/or Guardian

Date



PATIENT’S BILL OF RIGHTS

As a person receiving mental health services, you have the right to:

- Be treated with dignity and respect.
- Choose the services or programs in which you participate based upon information about rules, treatment procedures, costs, risks, rights, and responsibilities.
- Ask questions and get answers about services.
- Participate fully in treatment or services.
- Receive treatment in the least restrictive setting – one that provides the most freedom appropriate to your treatment needs.
- Refuse treatment or service unless ordered by the Court to participate.
- Be informed about the rules that will result in discharge from a program in violated.
- Participate fully in decisions regarding your discharge from a program and receive advance notice regarding the proposed discharge, unless your behavior threatens the well-being of another person.
- Know the name of the medication you are taking, why you are taking it, and what its possible side effects might be.
- Refuse to take medication, if you choose. (Note: You should not discontinue taking medication suddenly without first discussing the possible dangers with a psychiatrist.)
- Have your family involved in your treatment.
- Refuse family participation in your treatment, if you choose.
- Not be subjected to verbal, physical, sexual, emotional or financial abuse; harsh or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result.
- File a grievance if you are not satisfied with the response to a complaint.
- Be assisted by an advocate of your choice; for example, family, friend, care manager, case manager, member of a consumer advocacy committee or organization, etc.
- Review your record, with two exceptions. Limited portions of your records can be withheld from you if your provider has written that seeing specific information would:
 1. Be harmful to your treatment, or
 2. Reveal the identity or break the trust of someone who has provided information in confidence.
- Decide who else can see your records, with several exceptions. Those who do not need to ask your permission are: People involved in your mental health treatment or to whom you are referred for treatment, people providing emergency medical care, and attorney representing you at a commitment hearing, a court, people conducting program or utilization reviews, or third party payers (those who pay for your treatment). These people may only see as much information as they needed for the specific purpose requested.
- Manage your own financial affairs, in you choose, with one exception. If you receive Social Security benefits, the Social Security Administration might decide that you need a payee, based upon a psychiatrist’s report. If this happens, you have the right to choose the person who will be your payee. You can also regain the right to receive your Social Security check if a psychiatrist fills out a form saying you are now capable of managing your own money.
- Exercise all civil and legal rights afforded to citizens of the United States; for example, vote, marry, obtain a driver’s license, write a will, etc.
- Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.

I have read and understand the Patient’s Bill of Rights, and have received a copy to keep.

Patient and/or Guardian

Date



CEDAR CREST Joint Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Legal Duty

We are required by both federal and state law to maintain the privacy of your protected health information. We are also required to provide you with our Notice of Privacy Practices describing our legal duties, privacy practices and your rights with respect to your protected health information. This notice takes effect **April 14, 2003** and will remain in effect until we replace it.

Cedar Crest (Cedar Crest Hospital, Residential Treatment Center and Cedar Crest Clinic) and its employees, professional

Uses and Disclosures of Your Health Information

As required by law, Cedar Crest maintains your health information in a confidential manner. However, we must use and disclose your health information to the extent necessary to provide you with quality care. To do this, we must share your health information as necessary for treatment, payment and health care operations.

Treatment: This includes sharing information among health care providers involved in your care. For example: We may disclose health information about you to other health care professionals who are involved in taking care of you.

Cedar Crest physicians are “covered entities” under the law who may have access to your health information based on their role as your attending or consulting physician.

Payment: This includes sharing information for payment purposes. For example: We may use your health information as required by your insurer to obtain payment for your treatment or hospital stay.

Health Care Operations: This includes sharing information in connection with our health care operations. For example: Health care operations may include, but are not limited to, process improvement activities, evaluating health care provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Persons Involved in Your Care: We may release health

staff and volunteers must follow the privacy practices described in this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, as long as these changes are permitted by law. If we revise our Notice, we will follow the terms of the revised Notice as long as it is currently in effect. Before we make any significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time from the contact person listed at the end of this Notice.

information to the person responsible for your care or payment for your treatment, a family member, or your personal representative. If you are able and available to agree or object, we will give you the opportunity to object prior to disclosing any information. If you are unable or unavailable to agree or object, our health professionals will use their best judgment on disclosing only relevant health information.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment at Cedar Crest.

Public Health Activities: Public Health Activities may include: disease prevention; injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law).

As Required by Law: We may use and disclose your health information as required by law, subpoena, or other legal process.

Fundraising Activities: We may use limited health information about you to contact you in an effort to raise money for Cedar Crest and its operations. You will have an opportunity to refuse to receive these communications.

Coroners, Medical Examiners, and Funeral Directors: In order to carry out their lawful duties, health information may be disclosed to coroners, medical examiners, and funeral directors.

Patient Name: _____

Governmental Disclosures: Under certain circumstances we may disclose health information of Armed Forces personnel to military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information about inmates to correctional institutions or law enforcement officials having lawful custody.

Your Authorization: Except as described above, we will not use or disclose your health information unless you authorize Cedar Crest in writing to disclose your health information. You may revoke this authorization in writing at any time. Your revocation will be effective only after the date Cedar Crest receives your revocation. This revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Patient Rights

Access: You have the right to inspect and copy your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. Cedar Crest may charge a reasonable fee for copying and mailing.

Request Restrictions: You may request limitations on our use or disclosure of your health information. This request must be in writing and specify the limitations being requested. Cedar Crest is not required to agree to your request, but if we do agree, we will abide by the agreement.

Request Alternative Communications: You have the right to request that we communicate with you about your health information in alternative means or locations. For example, you may ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must be in writing and specify how or where you wish to be contacted. All reasonable requests will be accommodated.

Amendment: If you believe that the health information we have about you is incorrect or incomplete, you have the right to request that we amend your health information. This request must be in writing and explain why the information should be amended. Cedar Crest is not required to accept the amendment.

Accounting of Disclosures: You have the right to request a list of the disclosures of your health information that have been made to persons or entities other than for treatment, payment or health care operations, and certain other activities, for the past six years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you for the costs of providing the list.

Electronic Notice: You have the right to a paper copy of this Notice.

Questions and Complaints

If you want more information about our privacy practices, have a request concerning your patient rights, or have any questions or concerns, please contact us at the addresses listed below.

If you are concerned that we may have violated your rights or you disagree with a decision we have made regarding a request you submitted to us, you may contact us using the contact information located at the end of this form. You may also submit a written complaint to the Department of Health and Human Services. We will provide you with the address to file your complaint with the Department of Health and Human Services upon request.

We support your right to the privacy of your health information. You will not be penalized or retaliated against in any way for making a complaint to Cedar Crest or to the Department of Health and Human Services.

Contacts

Privacy Officer
3500 S. IH-35
Belton, TX 76513
(254) 939-2100

BY SIGNING THIS ACKNOWLEDGEMENT, YOU ARE SIMPLY INDICATING THAT YOU HAVE RECEIVED CEDAR CREST'S NOTICE OF PRIVACY PRACTICES. YOU ARE NEITHER CREATING NOR WAIVING ANY OF YOUR PATIENT RIGHTS.

Patient Name: _____
Date of Birth: _____

Signature of Patient (if 18 or older) Date
or Legal Guardian (if patient is
under 18)



Patient Questionnaire

DEVELOPMENTAL/SOCIAL/MEDICAL HISTORY – “PARENT’S REPORT”

Child’s Name _____ Age: _____ Sex: _____ Date: _____

Your Name and Relationship to Child: _____

Instructions: Please read each question, mark an “X” in the appropriate box and add comments where needed.

Mother’s Pregnancy with Child: If information for this section is unknown mark here: _____

Delivery: Vaginal C-Section Labor Induced: Y N Forceps used: Y N

Were there complications? Y N If Yes, Diabetes Premature Labor Toxemia Preeclampsia

Full Term Pregnancy: Y N If “No”, at how many weeks was your child born? _____

How much did your child weigh? _____ How long did your child remain in the hospital after giving birth? _____

Were tobacco, alcohol, or street drugs used during pregnancy? Y N If “yes”, explain: _____

DEVELOPMENTAL DELAYS: If information for this section is unknown mark here: _____

Mobility- Crawling, Walking: _____

Speech- 2 words 3-6 words together: _____

Potty trained (Out of diapers) 1½-2 2 ½ - 3 yrs 3-3 ½ years older than 3 ½ yrs

SOCIAL: Does your child talk easily with others? Y N Does your child play well with other children? Y N

Does your child have friends? Y N Is your child sexually active? Y N

(comments): _____

Support System:

Does your child have supportive relationships? Parents Grandparents Siblings Aunts/Uncles
 Close Friends Boyfriend/Girlfriend Guardians Church Family Other _____

RELIGION & SPIRITUAL ORIENTATION: If information for this section is unknown mark here: _____

Religious Preference: _____

Does your child attend church/synagogue/mosque? Y N _____

How important is your child’s faith in his/her everyday life? (rate on a scale of 1-10 with 10 – highest) _____

Is there a spiritual issue troubling your child? Y N _____

Patient Name: _____

MEDICAL REVIEW OF SYSTEMS – “PARENT’S REPORT”

Check if problems are current or past.

Eating Habits: Is your child a picky eater? Y N Does your child have any unusual eating habits? Y N

Comments about eating: _____

Sleeping: How many hours does your child sleep? _____ How long does it take your child to fall asleep? _____

If your child wets the bed, how often does this occur? _____

When was your child’s last physical exam? _____ **Last dental exam?** _____

<u>Has your child ever had the following tests:</u>	<u>Date</u>	<u>Results</u>
Hearing tests/Vision tests <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
EEG (Brain wave tests)? <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
CAT scan/MRI (Brain Scan) <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
EKG (heart test)? <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
Neurological Evaluation <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____

Does your child have a history of head trauma? Y N At what age? _____ Was there a loss of consciousness? Y N

If yes, please explain: _____

Past or Present medical condition? Y N *If yes, list year and the reasons:* _____

Medical hospitalizations? Y N *If yes, list year and the reasons:* _____

Surgeries/operations? Y N *If yes, list year and the reasons:* _____

Immunizations Received: Up-to-date, details unknown

Hepatitis B <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	Polio (OVP) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?
Diphtheria/Tetanus/Pertussis (DTP) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	Measles/Mumps/Rubella (MMR) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?
Hemophilus Influenza (HIB) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	Chicken Pox (VARICELLA) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?

Has your child ever had Chicken Pox? Y N If yes, when and at what age? _____

Please list upcoming appointments for: Medical, Dental, Therapy, Psychiatrist, Psychological testing or school testing : _____

Family Medical History: Has the patient’s parents, brothers, sisters or children ever had (check boxes and indicate):

If information for this section is unknown mark here: _____

- | | |
|---|---|
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Lung Problems _____ |
| <input type="checkbox"/> Psychological Problems _____ | <input type="checkbox"/> Stomach Problems _____ |
| <input type="checkbox"/> Thyroid _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Heart Problems _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Kidney Problems _____ |
| <input type="checkbox"/> Diabetes _____ | |

Patient Name: _____

DEPRESSION/SELF-HARM/SUICIDE

Note: Indicate INTENSITY and DURATION of symptoms if applicable.

- Y N Depressed mood/hopelessness: _____
- Y N Frequent crying episodes: _____
- Y N Sleep disturbance: falling asleep staying asleep early AM awakening restlessness
excessive time in bed decreased need for sleep (*mania*) _____
- Y N Appetite change: decreased increased _____
- Y N Weight change: gain loss _____ lbs. Current Weight: _____ Height _____
- Y N Fatigue, low energy _____
- Y N Loss of interest in activities, hobbies, or school _____
- Y N Low concentration/indecisive _____
- Y N Agitated mood/Irritable _____
- Y N Low self-esteem/Worthlessness _____
- Y N Excessive guilt _____

- Y N Past suicide attempts, acts of self-harm, or recurrent thoughts of death/suicide?
- Y N **Has patient thought about suicide or wished he/she was dead? (within past 48 hours)**
- Y N **Has patient engaged in any self-harmful behavior? (within past 48 hours)** _____
- Y N **Does patient have a suicide plan?**
- Y N Was this evaluation precipitated by a self-harm act/thought?
- Y N Can patient contract for safety? _____

HOMICIDE-VIOLENCE/LEGAL CHARGES

NOTE: Indicate INTENSITY and DURATION of symptoms, is applicable.

- Y N History of legal charges (circle): current pending past _____
- Y N History of being in a detention center? Where and when: _____
- Y N History of being on probation? Where and when: _____

- Y N Has patient EVER had violent/assaultive behavior towards others? _____
- Y N Has patient had homicidal/violent thoughts towards others (in the past 48 hours): _____
- Y N Has patient had violent/assaultive behaviors toward others (in the past 48 hours): _____
- Y N Has patient ever had a Protection Order filed against them? _____

Patient Name: _____

MANIA/ANXIETY

Note: Indicate INTENSITY and DURATION of symptoms, if applicable

- Y N More talkative than usual or pressure to keep talking _____
- Y N Elevated or expansive mood (*mania*) _____
- Y N Increase in goal-directed activities _____
- Y N Excessive involvement in pleasurable activities with potential for painful consequences (e.g. sexual promiscuity) _____
- Y N Flight of ideas/Racing Thoughts _____
- Y N Anxiety/Excessive worry/Panic _____

- Y N Worries about social interaction _____
- Y N School refusal _____
- Y N Frequent need for reassurance _____
- Y N Difficulty sleeping alone _____
- Y N Difficulty leaving parents/Being away from home _____
- Y N Worries about parental welfare _____

SUBSTANCE ABUSE HISTORY

- Y N Use of tobacco products. *What and how much:* _____
- Y N Caffeine consumption (circle): coffee soda iced tea hot tea
How much: _____

<input type="checkbox"/> Y <input type="checkbox"/> N Does patient drink alcohol? <i>What and how much:</i> _____
<input type="checkbox"/> Y <input type="checkbox"/> N Is patient currently using illegal drugs or abusing prescription or non-prescription medication? If yes, please list: _____ _____ _____
<input type="checkbox"/> Y <input type="checkbox"/> N During the past year, did patient drink or use more drugs than intended?
<input type="checkbox"/> Y <input type="checkbox"/> N In the past year, did patient want or feel a need to cut back on their alcohol or drug use?
NOTE: Complete the DRUG/ALCOHOL ASSESSMENT if any of the last three questions are "Yes."

- Y N Has patient abused alcohol/drugs in the past? _____
- _____
- _____

HISTORY OF ABUSE
NOTE: Indicate INTENSITY and DURATION of symptoms, if applicable.

Y N Sexually abused (circle): current past _____

Y N Physically abused (circle): current past _____

Y N Other (circle) **Verbal Emotional Neglect Abandonment** (indicate current or past)

Y N **Family Violence** (circle) current past _____

Y N **Is patient a perpetrator of abuse (circle): Sexual Physical Verbal Emotional**
(Indicate past or present)

Y N Does patient feel safe in current living situation? _____

Y N Has abuse been reported? To whom & when? _____

Y N Is Children's Protective Service involved? How? _____

POST TRAUMATIC STRESS DISORDER - (PTSD)
Note: Indicate INTENSITY and DURATION of symptoms, if applicable.

Y N Recurrent, distressing dreams of traumatic events, flashbacks _____

Y N Feelings of detachment from others _____

(additional PTSD comments): _____

BEHAVIOR CHECKLIST – “PARENT’S REPORT”

(Parents please check “Y” or “N” for all behaviors)

Attention Deficit/Hyperactivity Behavior (Check those that occurred before age 7)

(Staff Comments: Indicate INTENSITY and DURATION of symptoms, if applicable)

- Y N Restless, fidgets, short attention span, cannot remain seated _____
- Y N Excessive energy, acts as if driven by a motor _____
- Y N Talks excessively, cannot play quietly, interrupts others _____
- Y N Avoids tasks which take time and effort/has difficulty organizing tasks _____
- Y N Frequently loses things, often forgetful _____

Oppositional/Defiant Behavior

- Y N Angry, resentful, blames others for own mistakes _____
- Y N Frequently tries to get back at others/vengeful _____
- Y N Often loses temper _____
- Y N Frequent use of obscenities _____
- Y N Refuses to comply with adult requests/will argue with adults _____

Conduct Problems/Criminal Behavior

- Y N Has used a weapon _____
- Y N Cruel to animals _____
- Y N Cruel to people _____
- Y N Has deliberately set fires _____
- Y N Destructive to property, broken into homes, business, cars _____
- Y N Stealing: money or objects _____
- Y N Lies to obtain favors or objects _____
- Y N Has forced someone into sexual activity _____
- Y N School detentions, suspensions, truant, runaway _____

Patient Name: _____

CURRENT SERVICES – “PARENT’S REPORT”

PSYCHIATRIC MEDICATION MANAGEMENT	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
OUTPATIENT THERAPIST	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
FAMILY PHYSICIAN (PCP) OR PEDIATRICIAN	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
CHILD PROTECTIVE SERVICES	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
COUNTY MH-MR	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
SCHOOL CONTACT	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
PROBATION OR PAROLE OFFICER	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
SUBSTANCE ABUSE TREATMENT	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
(OTHER)	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____

Questionnaire Completed by: (X) _____
(Signature of parent/guardian and relationship)
_____ (date and time)

Questionnaire Reviewed by: (X) _____
(Staff signature and title)
_____ (date and time)