Medical/Safety Screen

Temperature

Consult Provider if > 100

* F: _____ Site: _____

Comment: _____

Pulse

Consult Provider if < 50 > 140 or irregular

B/min.: _____ Position: _____ Site: _____ Type: _____

Comment: _____

Respirations

Consult Provider if < 12 or >28

Per Minute: _____ Vent: _____

Comment: _____

Blood Pressure

Consult Provider if Diastolic > 110 or Systolic >180

Systolic (mmHg): _____ Diastolic (mmHg): _____ Position: _____ Side: _____

Comment: _____

Breathalyzer

Consult Provider if > 0.3

_____%

Have you been injured today or recently? YES ☐ NO ☐

If yes, have you been assessed by a provider?: _____

Have you tried to harm yourself today? YES ☐ NO ☐

If yes, explain: _____

Is there a chance you might be pregnant? YES ☐ NO ☐ N/A ☐

Last menstrual period: _____

Explain (Menopause/Other): _____

Allergies: _____

Current Medical Problems: _____

Is there a life-threatening medical emergency? YES ☐ NO ☐ Emergency Transfer Initiated ☐

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Screening Symptoms

(TO BE COMPLETED ALONG WITH REGISTRATION FORM)

Does the patient report infection symptoms at this time? YES ☐ NO ☐

Screening Symptoms:	If yes, Select Below	Describe Symptom & Onset
Fever	☐	
Cough	☐	
Runny nose	☐	
Body aches	☐	
Headaches	☐	
Chills	☐	
Fatigue	☐	
Diarrhea	☐	
Vomiting	☐	
Sore throat	☐	
Rash	☐	
Eye drainage	☐	
Kidney/urinary pain	☐	
Blood in cough	☐	
Shortness of breath	☐	
Unexplained weight loss	☐	
Swollen glands	☐	
Dizziness	☐	
Chest pain	☐	
Confusion	☐	
Stiff neck	☐	
Excessive bleeding	☐	
MRSA	☐	
C-Diff	☐	
Night sweats	☐	

Are you susceptible to infections that are difficult to treat?

YES ☐ NO ☐ UNABLE TO DETERMINE ☐

If yes, explain: _____

Within the last 30 days have you or someone you are in close contact with traveled outside of the U.S.?

YES ☐ NO ☐

If yes, explain relationship & where travel occurred: _____

In the past 2 weeks, have you been exposed to, or treated for bed bugs, lice, or scabies?

YES ☐ NO ☐

If yes, explain: _____

In the past 2 weeks, have you been treated for any infection or injury?

YES ☐ NO ☐

If yes, explain: _____

In the past 2 weeks, have you been exposed to Monkeypox?

YES ☐ NO ☐

If yes, explain: _____

Are you currently on an antibiotic or steroid?

YES ☐ NO ☐

If yes, please state the name of the medication, date started, and reason for taking the medication:

_____

Patient Signature: _____ Date: _____ Time: _____

Staff Use Only

Staff Name: _____

Staff Signature: _____ Date: _____ Time: _____

For any positive findings review with RN and answer:

YES ☐ NO POSITIVE FINDINGS ☐

If yes, explain positive findings:

_____

Reviewed with Nurse:

RN name: _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Authorization for Follow-Up Communication

By signing and providing your cellular number below you are consenting to follow-up communication by either text or phone regarding and stay with SUN Behavioral. Follow-up calls or text would pertain to, but not limited to, the following: Wellness check, overall satisfaction, potential feedback, and appointment reminders. We appreciate you choosing SUN Behavioral and look forward to your feedback.

Authorization for Follow-Up Communication

- ☐ I authorize SUN Behavioral to employ a third-party automated outreach messaging system to obtain overall patient satisfaction and feedback
- ☐ I authorize SUN Behavioral to notify me for appointment reminders and Wellness check
- ☐ I authorize SUN Behavioral to contact me at this phone number: _____
- ☐ Patient declined authorization

Patient Signature: _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Application for Voluntary Admission

Ohio Department of Mental Health and Addiction Services: Application for Voluntary Admission

In Accordance with Section 5122.02m 5122.03 ORC Name & Location of Facility: SUN Behavioral Columbus 900 E Dublin Granville Rd. Columbus, Ohio 43229

Name of Applicant: _____ Birth Date: _____ Age: _____

Address: _____ Address Line 2: _____

City: _____ State: _____ Zip: _____

Applicant's County of Residence: _____

Application:

To The Attending Physician: In accordance with the provision of the Revised Code of Ohio, application is hereby made for such care and treatment that may be necessary in promoting the recovery of the patient. It is specifically understood and agreed that if the patient is admitted to the hospital as a voluntary patient: 1. That the patient will abide by all the rules and regulations of the hospital. 2. That the patient will leave the hospital on the request of the Chief Clinical Officer of the hospital, if the patient requires different care or treatment than that provided by the hospital. 3. That the patient may request in writing his/her release from the hospital. The Chief Clinical Officer of the hospital then must either discharge the patient forthwith or file an affidavit for involuntary commitment within three court days of receipt of the letter requesting release. Note: If patient is under eighteen years of age, this application must be signed by a parent or guardian of the person having the legal custody of said minor. If the patient is an adult incompetent, the application must be signed by his guardian or by the person having custody.

☐ Telephone Consent Obtained

Signature of Patient: _____ Date: _____ Time: _____

Signature of Patient Guardian, or Custodian: _____ Date: _____ Time: _____

Signed in the presence of:

Witness: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

IOP - Conditions of Admission/Consent to Treatment and Information Disclosure- Ohio

Conditions of Admission/Consent to Treatment and Information Disclosure:

Patient Name (Hereinafter. "I" or "Me"):_____

Medical/psychiatric:

I understand that I will be under the care of my attending physicians and consent to any psychiatric, medical or Hospital services rendered to me under the general and special instructions of the physician. I realize that all physicians furnishing services to me, including, without limitation, the radiologist, pathologist, anesthesiologist and the like, may be independent contractors and not employees or agents of the Hospital. I understand that if I appear to be dangerous to myself or to others, the staff will exercise the necessary restraints in order to protect me and/or others.

Consent to Intensive Outpatient Program treatment:

I CONSENT TO RECEIVE INTENSIVE OUTPATIENT TREATMENT FROM SUN, WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, EVALUATION AND TREATMENT, OTHER THERAPEUTICS, AND ROUTINE MEDICAL AND NURSING CARE. THE TYPE AND EXTENT OF SERVICES THAT I RECEIVE WILL BE DETERMINED FOLLOWING AN ASSESSMENT AND THOROUGH DISCUSSION WITH ME. I UNDERSTAND THE GOALS AND POTENTIAL BENEFITS OF IOP TREATMENT AND RISK OF THE PROPOSED CARE. TREATMENT AND SERVICES HAVE BEEN EXPLAINED TO ME. ADDITIONALLY, I UNDERSTAND THE REASONABLE ALTERNATIVES AND THEIR BENEFITS AND RISKS RELATED TO NOT RECEIVING THE PROPOSED CARE, TREATMENT OR SERVICES HAVE BEEN EXPLAINED TO ME.

Medical emergencies:

I understand that during hospitalization at SUN, medical emergencies may arise that my medical providers believe would be best treated at a general acute care facility. For this reason, I authorize my transport to the nearest general acute care facility to be treated for any condition that might occur.

Contraband items:

I understand that drugs, alcohol, weapons, sharps, cell phones and other specified as contraband will not be permitted on site during the Intensive Outpatient Program. Cell phones will be required to be locked up and checked only during breaks from group time.

Violence-zero-tolerance policy:

I understand that SUN enforces a zero-tolerance policy regarding violence (verbal or physical), and that SUN has the right to pursue legal action against any patient who engages in violence, either verbal or physical, against staff members, patients, visitors or others while on Hospital premises.

SUN is committed to preventing, reducing and striving to eliminate the use of restraints:

The use of restraints is limited to emergencies where there is an imminent risk of self-harm or harm to others. In the adult program with your consent, your family will be involved in your treatment; this will include notification, with the patient's permission, of a restraint episode (parents/guardians will always be notified for adolescence/children to the extent permitted by applicable law).

Property damage:

I understand that I will be billed for any damage I cause to Hospital property and that I must pay for the cost of repair or replacement in full on/before discharge.

Photographs & camera surveillance:

I hereby consent to the taking of my photograph for the purpose of identification and/or treatment. The photograph may be permanently retained in my medical records. I understand that a patient identification wrist band may be used in lieu of a photograph for identification purposes. I understand that the photograph will be used only for the purposes described, and will not be otherwise released without my express permission. Further, I acknowledge and am hereby informed that the Hospital uses real-time video surveillance and recording equipment on its program units, This equipment is used solely for monitoring the patient areas for safety. Video surveillance and recording equipment is used in common areas and is never used in a patients bedroom or bathroom.

Physician/professional services:

Physicians will bill separately for their services. I understand that I may incur bills for specialized services provided by physicians in the Hospital other than from my attending physician. Acceptable payment arrangements must be made with the physicians business offices. I understand that it is my responsibility to communicate with physician offices so that I will have a clear understanding of their billing/collection policies.

Assignment of benefits and authorization to release payment information:

In consideration of the services rendered to me by SUN, I hereby transfer and assign to SUN all right, title, and interest in any payment due me for said services as provided by any and all policies of the insurance or other health care covered contract in which lam a

covered beneficiary, including, as applicable, Medicare/ Medicaid, I have provided my complete and accurate insurance information on the forms provided by SUN and hereby assign and transfer any and all benefits payable for Hospital and practitioner services relating to services provided by SUN and/or my attending and consulting practitioners, and hereby authorize SUN and said practitioners or practitioner organizations to submit claims therefor. I hereby authorize the release of any information requested by said insurance company(s), its representatives, third party payers or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement and appoint SUN and said practitioners or practitioner organizations as my agent(s) for the purposes of billing and collecting such fees. I understand that such disclosures may contain information regarding substance use, mental illness or developmental disability, physical abuse or neglect, sexual assault and/or sensitive records relating to psychiatric treatment and that this information may result in limitation or denial of insurance benefits or third party reimbursement. Nevertheless, I hereby release and hold SUN, all agents and treating practitioners harmless of and from any and all costs, loss, damage or liability resulting from any such disclosure(s).

Financial agreement:

I understand that SUN is not responsible for collecting insurance, or for resolving any disputed insurance or other third-party payer claims, and promise unconditionally to pay SUN all costs and charges incurred in connection with my hospitalization pursuant to this admission, It is agreed that if full payment is not made by insurance or other third party payers within thirty (30) days, I will make payment in full I acknowledge that failure to pay the Hospital account may result in referral of the said account to a commercial collection agency and/or credit bureau. Should the account be referred to any agency or attorney for collection, I shall pay SUN s reasonable attorney fees and collection expenses. Any questions or concerns regarding billing, insurance, or payment arrangements should be discussed with the hospital's patient account representatives in the business office at 614-706-2786.

Loss of personal property/money:

I release SUN from any liability for loss of or damage to my personal property. Furthermore, it is understood and agreed that SUN shall not be liable for the loss or damage of any money, personal valuables, or other articles. SUN will not reimburse patients or families for items brought into the Hospital that are lost or stolen. A safe is available for small personal items such as jewelry, billfolds, etc. (when there is no one to take them home or keep them safe for you until discharge). I further understand it is my responsibility to retrieve these items upon discharge and that the Hospital may discard them if I do not retrieve them within 30 days following my discharge.

Non-denominational church services:

If this consent is executed by a guardian of the patient, the undersigned hereby consents for patient to attend non-denominational religious services available at SUN, if the patient so chooses.

Consent for observation and assistance:

I understand that SUN is affiliated with academic institutions in the community. I consent that residents, interns, medical and nursing students, and other healthcare professional students can observe and assist in my care and treatment under the supervision of SUN staff and my physician.

Consents regarding substance use disorder information:

I understand that to the extent my medical records contain information regarding substance use disorder, the records may be subject to the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and that this information not be disclosed without my consent unless otherwise permitted by 42 CFR Part 2 (such as in the case of an emergency or by judicial order). I hereby consent to the Hospitals and my treating provider's disclosure of such information to my past, present, and future treating providers for the purposes of treatment, quality improvement, and/or the Hospitals operations, as well as for payment purposes (as described above). I understand that upon my written request, the Hospital will provide me with a list of recipients of my covered substance use disorder information in accordance with 42 CFR §2.13(d). I understand that I have the right to revoke this authorization at any time except to the extent action has been taken in reliance on my authorization. Unless I revoke this authorization, it will expire upon my death. I understand that the unauthorized disclosure of my substance use disorder records is prohibited by federal law and that I may report suspected violations, including, without limitation, to Hospital personnel. Notwithstanding the foregoing, I understand that the reporting of information regarding my commission of crimes on the Hospital premises and any reporting of child abuse and/or neglect is not prohibited. Disclosures covered by this section will be made with the following written statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identities a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder; except as provided in §2.12(c)(5) and 2.65.

Advance directive acknowledgment:

☐ I have been given written material about my rights to formulate advance directives, both medical and mental health.

YES ☐ NO ☐ I have executed an advance directive for medical treatment. (I understand that a do not resuscitate [DNR] request is not honored at SUN.)

YES ☐ NO ☐ I have executed a Declaration for Mental Health Treatment.

Did you bring a copy? YES ☐ NO ☐ N/A ☐

If no, will you provide SUN with a copy? ☐

If no, check to acknowledge that a copy is not available ☐

I have reviewed, understand and have received a copy of my patients rights and notice of privacy practices. **(PATIENT MUST SIGN)**

Signature of Patient/Guardian: _____ Date: _____

Staff Signature: _____ Date: _____

The undersigned certifies:

The undersigned certifies that he/she has read the foregoing, received a copy, and is the patient or parent/legal guardian if the patient is a minor is otherwise not legally able to complete this consent on his/ her own behalf. If this document has been executed by a parent/legal guardian of the patient, all references to the patient above shall be deemed to have been made by the parent/legal guardian on behalf of the patient.

Print Name of Patient/Guardian: _____

Relationship to Patient: _____ Signature: _____ Date: _____

Print Name of Admission Staff: _____

Signature: _____ Date: _____

Verbal Consent Obtained:

Reason why verbal consent necessary: _____

Verbal consent obtained from: _____ Relationship to patient: _____

Staff name: _____ Staff signature: _____

Date: _____ Time: _____

Witness name: _____ Witness signature: _____

Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Personal Property/Valuables Inventory

Is there Currency? Total: _____

Currency Removed:

Date Given to Patient	Amount Given	Staff Initials	Comments

Patient Valuables:

Date In	Item Description (be specific)	Location

Patient Valuables (Continued)

Staff Initials	Date Out	Staff Initials

Patient Personal Property:

A correct listing of my personal effects that are being kept by the hospital are listed on the Personal Property/ Valuables Inventory page. I relieve the hospital staff of any loss or damage to my valuables where reasonable safety precautions have been taken. I take full responsibility for articles kept by me, and any article brought to me at a later date. I understand that it is my responsibility to request that items kept by the hospital be retrieved to me upon discharge. Any items that I do not claim, or that are not returned within 30 days of my discharge, may be disposed of.

Signature of Patient/
Guardian at admission: _____ Date: _____ Time: _____

Note(s):

_____

_____

_____

Discharge Property Disposition:

I (patient/guardian) acknowledge that I have received all the items brought to the hospital and will not hold SUN Behavioral or its staff responsible for any items left behind at the time of my discharge.

Signature of Patient/
Guardian at admission: _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Telephone/Visiting List

Telephone/Visiting List

I give consent for the following individuals to be involved in visitation and/or phone calls as noted. I will provide these individuals with the patient identification number assigned and understand that, without this number, the individual will not be allowed to visit or call me. I further understand that I can add or delete this list at any time during my stay. I understand that flowers or other deliverable arrangements cannot be accepted in order to maintain patient confidentiality. To maintain confidentiality rules and guidelines, cell phones belonging to ANY individual are not allowed in the intake department, outpatient area or inpatient units at this facility. Please include any phone numbers you will need during the intake process and/or inpatient stay. Cell phones will be safely stored for you once out of the front lobby area in a security bag labeled with your information. Instead, if you prefer, please feel free to lock cell phones in your car or send them home with a family member/friend. Cell phones will be returned as you are leaving. This form does not allow for the release of information related to medical, mental health and/or substance use records. This information requires a separate release of authorization.

Patient Name: _____

Telephone/Visiting List

Name	Relationship	Phone Number	Phone Calls	Visitations	Date	Time

Consent:

I, (Patient/Guardian), authorize, (Minor), to contact the above during phone times.

Patient/Guardian: _____ Minor: _____

Patient/Guardian Signature: _____

Title (Patient/Guardian): _____ Date: _____

Witness signature: _____ Date: _____ Time: _____

Verbal Consent for Release of Information:

Name of person giving verbal consent: _____ Date: _____

Comments: _____

_____

Please send completed forms to the following:
Email: admissions@suncolumbus.com • **Mail:** 900 E Dublin Granville Rd, Columbus, Ohio 43229 • **Phone:** (614) 796-0510

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____