

Health Connections ~ Driver Intervention Program

Business Address: 6600 Sylvania Avenue, Suite 264, Sylvania, Ohio 43560

Phone: (419) 517-4088 ext. 3 Email: dip@healthconns.com Fax: (419) 517-4089

DIP INTAKE and REGISTRATION FORM

Participant Name

Program Date

Phone Number

Gender

Pregnant?

Street Address

City

State

Zip Code

Email Address

Marital Status

Employer

Work Phone Number

Full Time Student: Yes No

If yes, where?

Any special needs? (If yes, provide details.)

Referral Source (Referring Court)

Person Responsible for Payment

Current Medications

Allergies (Medications, Food, Bee Stings, etc.) and/or Special Dietary Requirements

Emergency Contact Information

Contact Name

Relationship to Participant

Phone Number/s

Address

Staff only: Baggage has been inspected to ascertain the presence of any contraband.

Intake information has been reviewed.

Staff Signature

Date

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AUTHORIZATION TO DISCLOSE CLIENT INFORMATION

Name of Participant

Date of Birth

The following programs are authorized to: disclose, receive, or exchange information as noted below.

Health Connections, 6600 Sylvania Avenue, Suite 264, Sylvania, Ohio 43560

Program Authorized to Make Disclosure

EMERGENCY CONTACT NAME:

CONTACT PHONE NUMBER:

Authorized Individual/Organization to Whom Disclosure Is Made

Purpose of Disclosure: To coordinate referral for assessment, To inform referral source of DIP attendance, To inform legal representative, To coordinate treatment, Other purposes [specify]:

EMERGENCY CONTACT

Type of Information to be Disclosed: DIP Intake, DIP Screening, Attendance, Assessment, Completion Report, DIP Small Group Notes, DIP Education Log, Diagnosis, Other information [specify]:

INFORMATION RELEVANT TO AN EMERGENCY

Amount of Information to be Disclosed: Information covering the current DIP, Other amount of information [specify]:

LOCATION AND INFORMATION IN THE EVENT OF AN EMERGENCY

Signature of Participant or Other Person Authorized to Permit Disclosure

Date

Signature and Date of Staff or Witness

Revocation: This authorization is subject to written revocation at any time except to the extent that the program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke consent: _____

This authorization expires: There has been a formal and effective termination of the proceeding under which I was mandated into the DIP, 90 days, 180 days, 3 days after completion of the DIP, Specify other expiration:

Signature and Date of Staff or Witness

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any information to criminally investigate or prosecute any alcohol or drug abuse client. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 [HIPAA], 45 C.F.R., parts 160 and 164. [These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.]

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Program Authorized to Make Disclosure

Referring Court/Authorized Individual/Organization to Whom Disclosure Is Made

Purpose of Disclosure: To coordinate referral for assessment, To inform referral source of DIP attendance, To inform legal representative, To coordinate treatment, Other purposes [specify]:

Type of Information to be Disclosed: DIP Intake, DIP Screening, Attendance, Assessment, Completion Report, DIP Small Group Notes, DIP Education Log, Diagnosis, Other information [specify]:

Amount of Information to be Disclosed: Information covering the current DIP, Other amount of information [specify]:

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Participant Name:

By signing below, I acknowledge the following:

Fee Agreement: *I have paid for a*

shared room

private room

for Health Connections 72- Hour Driver Intervention Program.

I consent to receive Driver Intervention Program services.

I have received a copy of the education curriculum for the Driver Intervention Program.

I have received the Driver Intervention Program Rules/Expectations.

I have received the Participant Rights and Grievance Procedures.

I have received and understand the written summary of the Federal Laws and Regulations pertaining to the confidentiality of client records and required by 42 C.F.R., Part 2.

I have received fire evacuation procedures at this program site.

Participant Signature

Date

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I, [REDACTED], acknowledge that I have been oriented by Health Connections' staff to the Driver Intervention Program Handbook. I have received a copy of the Driver Intervention Program Handbook, as well as the paperwork described below.

Participant Intake and Orientation Checklist

Required Documents	Participant Initials
Educational Curriculum	
Program Rules/Expectations	
Participant's Rights & Policies	
Grievance Procedure	
Confidentiality of Client Records (<u>42 C.F.R.</u> , Part 2)	
Prescription Medication List	
Code of Ethics	
Authorizations to Release Information	
Fee Agreement	

Participant Signature: _____ Date: _____

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CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Participant's Name

Date of Birth

My personal health information is private and confidential. I understand that my provider works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my provider may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my provider to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my provider does not have to agree to my request. If my provider agrees with my request, I understand that my provider would follow the agreed limits.

I may cancel this consent at any time by doing the following:

Writing, signing, and dating a letter to my provider directly. If I write a letter, it must say that I want to cancel my request to authorize the use and disclosure of my personal health information for treatment, payment and health care operations.

If I cancel this consent, my provider does not have to provide any further health care services to me.

My signature below indicates that I agree to allow my provider to use and disclose my personal health information to carry out treatment, payment and health care operations.

Participant Signature

Date

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CONSENT TO TREATMENT

IN CONSIDERATION OF MY BEING ACCEPTED FOR SERVICES, I HEREBY AGREE TO THE FOLLOWING:

- 1) That I hereby grant the employees, agents, or members of Health Connections permission to perform such services and provide such structure as appropriate for my care and the safe, orderly, and therapeutic operations of the program. I recognize that either program staff or myself has the right to immediately terminate my services at any time.
- 2) That I will hold Health Connections, its agents, members or employees free from all liability from losses through fire, theft, or personal injury while I am in or about the premises of the same.
- 3) That if I miss any sessions, without being excused, I can be held responsible for paying for the missed session.
- 4) That if I miss any sessions, without being excused, this can lead to termination.
- 5) The fee for the Driver Intervention Program is non-refundable.
- 6) That although insurance might be billed, I am ultimately responsible for all charges.
- 7) I have been informed of hours of operation.
- 8) I am consenting to services. YES NO
- 9) Please indicate if you have an Advance Directive (Living Will). YES NO
- 10) I have received Health Connections HIPAA Policy. YES NO

Participant's Signature

Date

Michigan Alcoholism Screening Test

Answer yes or no to the following questions:

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people)
 Yes No
2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?
 Yes No
3. Does any near relative or close friend ever worry or complain about your drinking?
 Yes No
4. Can you stop drinking without difficulty after one or two drinks?
 Yes No
5. Do you ever feel guilty about your drinking?
 Yes No
6. Have you ever attended a meeting of [Alcoholics Anonymous](#) (AA)?
 Yes No
7. Have you ever gotten into physical fights when drinking?
 Yes No
8. Has drinking ever created problems between you and a near relative or close friend?
 Yes No
9. Has any family member or close friend gone to anyone for help about your drinking?
 Yes No
10. Have you ever lost friends because of your drinking?
 Yes No
11. Have you ever gotten into trouble at work because of drinking?
 Yes No
12. Have you ever lost a job because of drinking?
 Yes No
13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?
 Yes No
14. Do you drink before noon fairly often?
 Yes No
15. Have you ever been told you have liver trouble, such as cirrhosis?
 Yes No
16. After heavy drinking, have you ever had [delirium tremens \(DTs\)](#), severe shaking, visual or auditory (hearing) hallucinations?
 Yes No
17. Have you ever gone to anyone for help about your drinking?
 Yes No
18. Have you ever been hospitalized because of drinking?
 Yes No
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
 Yes No
20. Have you ever gone to any doctor, [social worker](#), clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?
 Yes No
21. Have you been arrested more than once for driving under the influence of alcohol?
 Yes No
22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
 Yes No

This is one unit of alcohol...



...and each of these is more than one unit



Pint of "regular" beer, lager or cider

Pint of "strong" or "premium" beer, lager or cider

Alcopop or a 275ml bottle of regular lager

440ml can of "regular" lager or stout

440ml can of "super strength" lager or stout

250ml glass of wine (12%)

75cl Bottle of wine (12%)

AUDIT

	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

SCORE

