

**1005 KEOLU DRIVE
KAILUA, HAWAII 96734**

**TELEPHONE (808) 262-2799
FAX (808) 262-0970**

Referral Source	Date
Name/Title	Telephone

Funding Source (circle appropriate source)

Adult Mental Health (Authorization must be obtained)	Alcohol Drug Abuse Division
Adult Probation Department	Community Care Services
Veteran's Administration	Other (Manage Care)

Applicant's Data – Descriptor Information

Name _____ Date of Birth _____

Address _____

Telephone _____ Social Security No. _____

Has a psychiatrist diagnosed the applicant? Y _____ N _____

Is applicant currently under the care of a psychiatrist? Y _____ N _____

Name of Attending Psychiatrist _____ Telephone _____

Has the applicant ever been in the State Hospital? Y _____ N _____

Has the applicant ever been affiliated with any Hawaii State Mental Health Clinic?
Y _____ N _____

Reason for Referral ((Presenting Problems)

Does the applicant have a history of any of the following? **Must Be Answered**

Forensics Status – Legal Encumbrance Y _____ N _____

Violent/Assaultive behavior Y _____ N _____

Suicidal thoughts/attempts Y _____ N _____

Arson or child molestation Y _____ N _____

If yes, please describe _____

Does the applicant have a history of sexual and/or physical abuse? Y _____ N _____

If yes, please have applicant describe _____

Does the applicant want to address issues of abuse while in treatment with Po'ailani, Inc?
Y _____ N _____

Current Medications (minimum 2 weeks supply of medication required for admission)

Name	Frequency	Purpose	Last Dose	Effects

Is the applicant adherent with medication regime? Y _____ N _____

Is s/he capable of administering his/her own medication? Y _____ N _____

Has the applicant consistently taken medication for the last two weeks? Y _____ N _____

Does the applicant have any dental and/or medical problems that will require medical attention and treatment with narcotic medication (i.e., painkillers)? Y _____ N _____

NOTE: Prior approval for admission required from the Medical Director for an individual taking controlled substances.

Any chance that the applicant could be pregnant? Y _____ N _____

If yes, please describe _____

Previous Psychiatric Treatment History (Begin with last episode)

Has the applicant been hospitalized for psychiatric care in the past 12 months for treatment of major mental illness?

Y _____ N _____

If yes, please indicate below.

	Treatment Episode	Treatment Episode	Treatment Episode
When			
Where			
Length of Stay			
Modality			
Outcome			
What Led to the Relapse			
Difference This Time			

List additional psychiatric treatment events on separate sheet.

Previous Substance Abuse Treatment History (Begin with last episode)

Has the applicant been in treatment for substance abuse/dependency? Y _____ N _____

If yes, please indicate below.

	Treatment Episode	Treatment Episode	Treatment Episode
When			
Where			
Length of Stay			
Modality			
Outcome			
What Led to the Relapse			
Difference This Time			

List additional substance abuse treatment events on separate sheet.

Substance Abuse History

Is there a history of IV Drug Use?

Y _____ N _____

Substance Used			
Route of Administration			
Date of Last Use			
History of Overdose			
Withdrawal Symptoms			
Frequency of Use			
# of Years Used			
Age of Onset			

If the applicant has support from family, friends, and/or significant other, please provide name and contact number of individual(s) in support of applicant.

Name of Support Person

Contact Telephone Number

Financial Resources

NOTE: All participants are responsible for the following:

- Residential Treatment Monthly Program Fees **\$350.00**
- Residential Treatment Monthly Food Contribution **\$180.00**
- Group Housing Monthly Rent **\$350.00**
- Group Housing Monthly Food **Independent Purchases**

Does the applicant currently have money to pay the program fee and/or rent? Y _____ N _____

If so, how much money will the applicant have at the time of admission into treatment or entry into group housing? _____

Does the applicant currently have resources to contribute to the purchase of food or to independently purchase food to care for basic needs? Y _____ N _____

If yes, specifically indicate the available resources that the applicant will have at the time of admission into treatment or entry into group housing _____

What is the source of the applicant's monthly income (if any)? Please include all entitlements such as food stamps _____

Does the consumer exceed three hundred percent of the poverty level for Hawaii? Y _____ N _____

AMHD REFERRALS ONLY

NOTE: Po'ailani, Inc. requires that case managers put in requests for CRF funds with the DIVISION to provide financial support for applicants that do not have money, food, etc. to initially cover program fees, rent, food and other essential personal items prior to admission into residential treatment or entry into group housing. Please complete below if applicable.

Case Manager Name	Agency	Office Telephone	Alternate Telephone	CRF Request Date	Person Notified

Health Benefit Resources

If applicant has Quest health care benefits with managed care, circle the appropriate response below.

CCS

HMSA

KAISER

ALOHA CARE

HEALTH PLAN NUMBER _____

If applicant has other health care benefits, circle the appropriate response below.

MEDICARE

MEDICAID

HEALTH PLAN NUMBER _____

Vocational Educational History and Interest

Has the applicant completed high school? Y _____ N _____

Does the applicant have a GED? Y _____ N _____

If the answer to the above questions is no, is the applicant interested in obtaining a GED? Y _____ N _____

Is the applicant interested in participating in any type of educational program? Y _____ N _____

If yes, what are the interests the applicant? _____

Has the applicant been employed in the past (30) days? Y _____ N _____

Last Month/Year of employment _____ Last Employer _____

Is the applicant interested in participating or returning to work? Y _____ N _____

If yes, what are the work interests of the applicant? _____

Criminal Justice History

Is the applicant presently incarcerated? Y _____ N _____

If the applicant was previously incarcerated, please complete the following:

CHARGE	MONTH/YEAR	FACILITY	LENGTH INCARCERATED

What is the applicant's current legal status with the criminal justice system?

DSM – V Diagnosis

AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V (Current)	(Past)

NOTE: Po'ailani, Inc. requires a copy of a current psychiatric evaluation and/or discharge summary. Please forward copy to the Intake Specialist for consideration of admission into treatment.

AMHD REFERRALS ONLY

Po'ailani, Inc. requires a master treatment service plan (MTSP) from case managers for consumers to enter group housing.

PO'AILANI'S USE ONLY

APPROPRIATE PLACEMENT

Placement Decision			
Key Placement Dimensions (ASAM)		Severity Profile (note) H M L	
1. Acute Intoxication and/or Withdrawal Potential			
2. Biomedical Conditions and Problems			
3. Emotional/Behavioral Conditions and Problems			
4. Treatment Acceptance/Resistance			
5. Relapse Potential/Recidivism			
6. Recovery Environment/Family Support			

APPROPRIATE PLACEMENT (Complete Sections Below)

<u>ADMISSION DATE</u>	<u>TREATMENT MODALITY</u>			<u>HOUSING LEVEL</u>	
	RES	DAY	OPS	24-HR	8/16-HR

INAPPROPRIATE/INELIGIBLE (Complete Sections Below)

<u>REFERRAL DATE</u>	<u>REASON FOR INELIGIBILITY</u>
<u>REFERRAL INFORMATION</u>	

Staff Signature: _____ Date: _____

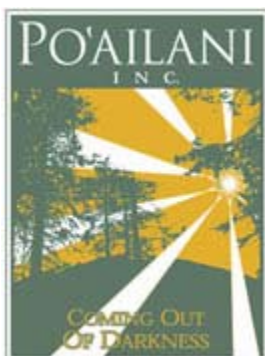
Packing List and General Information

The Po'ailani Dual Diagnosis Residential Treatment Program offers shared rooms with limited storage space. New admissions are permitted to bring in not more than one suitcase and one backpack.

To assure that all pre-admission requirements are met, new admissions will check in with the intake specialist at the Po'ailani administrative office located at 1005 Keolu Dr. in Kailua prior to being transported to the residential program.

- Special diet instructions/plan must be approved prior to admission, if applicable.
- TB clearance must be acquired before admission is complete.
- Bring all medications you currently take (do not bring in discontinued meds)
- Bring your EBT Card, ID & medical card.
- The monthly out of pocket expense for each client is \$350 for program fees and \$180 for food payable by EBT or cash upon arrival.
- Revealing clothing (braless tops, short shorts) and drug/alcohol logo T-shirts are not permitted.
- Do not bring illegal drugs, alcohol, drug paraphernalia or weaponry.
- Do not bring items of value such as jewelry, large amounts of cash or collectible items.
- Mouthwash, perfume, cologne & nail polish remover will be locked up and made available to the client at designated times of the day.
- Washers & dryers are available for client use. Laundry soap is provided.
- Po'ailani is a caffeine free program. A caffeine free soda machine is located on site.
- Phone privileges are available after one week of treatment.
- Sunday passes and family visitation are approved on a case-by-case basis after 30 days of treatment.
- Clients are not permitted to bring vehicles to the program.
- Po'ailani is not responsible for lost, stolen or damaged items.

Please contact Andre Lima, Intake Specialists, at 262-2799 with any further questions regarding admission into Po'ailani.





State of Hawaii Department of Health

Authorization for Use or Disclosure of Protected Health Information (PHI)

Name of Individual/Organization Disclosing Protected Health Information	
Name: State of Hawaii Department of Health Adult Mental Health Division	Address: P.O. Box 3378 Honolulu, Hawaii 96801-3378
Name of Individual/Organization That Will Receive the Individual's Protected Health Information	
Name: Po'ailani Inc.	Address: 74 Kihapai St. Kailua, HI 96734
Client/Patient Whose Protected Health Information is Being Requested	
First Name:	Last Name:
Address:	Birth Date (if known):

I authorize that the Following Protected Health Information be Used/Disclosed: (Be specific. Identify limits, as appropriate. Initial in the space provided if your authorization includes the use/disclosure of specially protected health information)

X ___ Mental Health X ___ Substance Abuse Treatment X ___ HIV/AIDS

The Protected Health Information is Being Used or Disclosed for the Following Purposes (*At the request of the Individual is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.*):

For Continuity of Care and for Purposes of receiving Funding

Authorization Duration (This authorization will be in force and effect until the date *or* event specified below. At that time, this authorization to use or disclose this protected health information expires)

Authorization Expiration Date:	Expiration Event That Relates to the Individual or the Purpose of the Use or Disclosure
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I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.

The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party.

Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative	Description of Personal Representative's Authority

Po'ailani, Inc.

Initial Psychiatric Evaluation

Name: _____ DOB: _____ Date of Evaluation: _____

Identification: _____ year old male female _____

Chief Complaint: _____

Referral Source: _____

Hx of Present Illness:

Substance Abuse Hx: _____

Past Psychiatric Hx: _____

Legal Hx: _____

Past Family Psychiatric Hx: Negative Positive: _____

Past Medical Hx: Allergies: NKDA Known Allergies: _____

Psychosocial Hx: (1) Developmental Hx: (2) Educational Hx: (3) Employment Hx: (4)

Past Trauma Hx: _____

Mental Status Examination:

Level of Consciousness: _____ Appearance: _____

Dress: _____ Hygiene: _____ Behavior: _____

Speech/Language: _____ Thought Process: _____

Thought Content: _____ Themes: _____

Dangerousness: _____ Mood: _____

Judgment: _____ Insight: _____ Affect: _____

Impulse Control: _____

Clinical Impression: (1) Presence of Dangerousness; (2) Appropriate Level of Care

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest GAF past year: _____

Additional Information: _____

Signature of Psychiatrist/Psychologist: _____

Date: _____

Print Name: _____

PO'AILANI, INC.
CONTINUUM OF CARE

Physical Examination Record

Name: _____ Date of Birth: _____

Address: _____
Street Number City Island Zip Code

Height: _____ Weight: _____ B/P: _____

TB Clearance: _____
Chest X-Ray _____ Mantoux: _____ Results: _____

Hgb: _____ Hct: _____ UA: _____

Others: _____

Eyes: _____ Pupils: _____ Ears: _____

Vision/Rt: _____ Vision/Lt: _____

Corrected Vision/Rt: _____ Corrected/Vision Lt: _____

Hearing/Rt: _____ Hearing/Lt: _____

Nose: _____ Thyroid: _____ Mouth: _____

Teeth: _____ Heart: _____ Rhythm: _____

Murmurs: _____ Abdomen: _____ Lungs: _____

Kidneys: _____ Hernia: _____ Skin: _____

Genitalia/
Pelvis: _____ Hemorrhoids: _____ Reflexes: _____

Varicosities: _____ Romberg: _____

Extremities/
Upper: _____ Lower: _____

Other Abnormalities: _____

Current Medications: _____

Diagnosis: _____

Diet: _____

Physicians Name: _____

Physicians Signature: _____ Date: _____