DESERT VISIONS YOUTH WELLNESS CENTER

198 S. Skill Center Road
P.O. Box 458
Sacaton, Arizona 85247
Tel: 888-431-4096

APPLICATION

For

ADMISSION

MISSION STATEMENT

Desert Visions Youth Wellness Center provides Native American people culturally relevant behavioral health treatment to intervene in addictive lifestyles, to assist in the development of dignity and self-respect while instilling hope and promoting wellness in adolescents, families and communities.

VISION STATEMENT

Desert Visions Youth Wellness Center is the path to wellness for Native American youth who are in need of substance abuse treatment and other behavioral health care.

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS AND BEHAVIORAL HEALTH PROVIDERS

Please read the following information:

- We recommend that this Application for Admission packet be completed by a health professional.
- We recommend that the Desert Visions three page history and physical examination form be used in lieu of other physical exam forms.
- We encourage you to mail the complete Application for Admissions to Desert Visions Youth Wellness Center, P.O. Box 458, Sacaton, Arizona 85247.
- A phone screen with the client will be performed by a Desert Visions staff as part of the admission process.
- A client will not be admitted to Desert Visions without a legal guardian present at the time of admission.
- Parents or guardians agree to attend one of the quarterly Circle of Strength family gatherings during the residents stay at Desert Visions.
- Community service may be performed while the client is enrolled in the Desert Visions program.
- A client will only be discharged to a legal guardian.

TREATMENT MODEL AND PHILOSOPHY OF CARE

The purpose of the Desert Visions Youth Wellness Center is to support as many clients as possible in their quest for a substance-free lifestyle. We hope to educate our clients about the negative impact of substance use on mind, body and spirit so that they in turn may educate others.

The clinical staff at Desert Visions uses the medical model in viewing alcohol dependence as a disease. Desert Visions staff is aware that social and environmental factors may contribute to stressors, which may result in substance use/abuse.

In using the biopsychosocial model, Desert Visions accepts the idea that a social problem in the life of an individual may result in psychological problems if not arrested in a timely manner. Desert Visions believes that in order to achieve the highest success a therapeutic alliance with clients and their family is of utmost importance.

Services are individual and culturally relevant to accommodate clients with dual diagnosis. Clients are introduced to a behavioral approach, utilizing positive reinforcement for appropriate behaviors. Staff will also redirect and provide consequences for inappropriate behaviors. Clients are taught about choices and natural consequences as a result of those choices. The goal of treatment is to better the client's social, emotional and behavioral realm.

The 12-step program is used as an adjunct to treatment. In addition, our clients are taught about Relapse Prevention so as to prepare themselves for re-entry with their families or other providers.

Desert Visions Youth Wellness Center
198 S. Skill Center Road, P.O. Box 458
Sacaton, AZ 85247
888-431-4096

Application Packet Checklist

Name	.	Legal Guardian

To ensure timely processing of application:

Provide Copies of: **COMMENTS**

* _____ **Social Security Card** _____
* _____ **Birth Certificate** _____
* _____ **Tribal Enrollment** _____
* _____ **Guardianship papers (if applicable)** _____
* _____ **Court Order to Treatment (if applicable)** _____
* _____ **Insurance Card** _____
* _____ **AHCCCS Card** _____

Complete all items and send originals of application materials in one packet. All signatures MUST BE in place and legible. Pages 5-12 must be completed by interviewer at the referring agency.

	Page(s)	Description
_____	3	Application Packet Checklist
_____	4	Admission Criteria
_____	5-12	*Client Identifying Information
_____	13	List of What to Bring (Males)
_____	14	List of What to Bring (Females)
_____	15	Transportation Responsibility
_____	16	Consent for Client Treatment
_____	17	**Consent to Photograph and Film Client
_____	18	Consent for Client to Participate in Outings and Wilderness Experiences
_____	19	Client Agreement
_____	20	Consent to Photograph and Film Client's Artwork
_____	21	Health Insurance Information
_____	22	***Consent for Haircuts
_____	23	Approved List of Client Contacts
_____	24	Consent Regarding Contact
_____	25	List of Address Needed for Release of Information
_____	26-28	History & Physical Exam -- *Acceptable Format*

*Completed and signed by interviewer at referring agency.

Items 11 & 12, on Page 12: Lower levels of treatment must be exhausted and client must meet the DSM IV-TR or ICD-10 criteria and be diagnosed by a credentialed or licensed provider.

**Two Polaroids are taken of client upon admission.

****Desert Visions may pay for two haircuts during treatment.*

_____ **Medical Alert**
_____ **Special Needs** _____ **Allergies**

Be sure clinic and doctor names are LEGIBLE. Must be done within 30 days of intake. Contain a statement saying client is stable for treatment at DV. (Must be done by Doctor, PA, or Nurse Practitioner). Must arrive with the packet. Packet cannot be submitted to Treatment Team for action without H & PE.

ADDITIONAL REQUIREMENTS:

_____ Immunization Record, Verification by Desert Visions Nurse: _____
Immunizations must be current/up-to-date.

_____ PPD (TB Skin Test), Date Read & Signature: _____
PPD (TB skin test) given and results read within past year with legible dates/signatures.

Desert Visions Youth Wellness Center

Admission Criteria

Criteria for Admission/Re-Admission to Desert Visions Youth Wellness Center shall include:

1. Age range between 12 and 18.

2. Must be an enrolled member of a federally recognized tribe, or provide proof of direct Tribal lineage or affiliation.

3. The client meets DSM IV or ICD-10 criteria for substance abuse disorder in accordance with standardized and widely accepted criteria as diagnosed by a credentialed or licensed provider.
   - There must be a primary diagnosis meeting DSM IV or ICD-10 criteria for substance abuse or dependence.
   - There may be a secondary Axis I or Axis II diagnosis. (Axis III diagnoses must be specified, including "No diagnosis".)

4. Completion of a health and physical examination, done within 30 days prior to admission.

5. Desert Vision staff will complete telephone screen with applicant and legal guardian prior to application approval.

6. Legal guardian must accompany client to Desert Visions on admission date to check minor into facility.

The following conditions may preclude admission to Desert Visions:

1. Medical instability - any person who is experiencing an acute medical problem that would interfere from benefiting from the treatment program.

2. Actively suicidal, homicidal and/or a history of violent behaviors sufficient to be a threat to staff or clients.

3. Actively psychotic or impairment in reality testing.

4. Refusal to participate in the treatment program.

5. Significant runaway risk – Desert Visions is not a lock down facility.

6. Behavioral problems that would interfere with other residents' treatment.

7. Intellectually challenged (any person having an I.Q. of 70 or less) or having other equivalent cognitive deficiencies which would interfere with treatment benefits.

8. Concurrent admission of a sibling.

PLEASE PRINT LEGIBLY- USE BLACK INK

Desert Visions Youth Wellness Center

Client Identifying Information

Date:_____

Client's Name: _____ Date of Birth_____ M [ ] F [ ] Age:_____

S.S.#: _____ Place of Birth: _____

Tribal Affiliation: _____ Degree of Indian Blood: _____ Religion: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

PARENTS:

Mother's Name:_____ Deceased?_____

Tribal Affiliation:_____

Address: (if different than above) _____ Phone: _____

City:_____State:_____ Zip:_____

Father's Name:_____ Deceased?_____

Tribal Affiliation: _____

Address: (if different than above) _____ Phone: _____

City:_____ State:_____ Zip:_____

Is the client Court Ordered to Treatment? Yes __ No __

What are the consequences of not completing treatment?_____

What are the consequences of AWOL (running?)_____

EMERGENCY CONTACT:

Name:_____ Relationship to Client:_____

Home Phone: _____ Work Phone: _____

LEGAL GUARDIAN:

Name:_____ Relationship to Client:_____

Tribal Affiliation:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone: _____

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PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

AFTERCARE COUNSELOR:

Name and Title: _____

Name of Program: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Pager #: ( ) _____

PROBATION OFFICER:

Name and Title: _____

Name of Program: _____

Address: _____

City; _____ State: _____ Zip: _____

Phone #: ( ) _____ Pager #: ( ) _____

A. EDUCATIONAL HISTORY:

I. Name of last school attended? _____,City/Town_____, State_____

Last grade completed? _____

2. Is client still in school? Yes [ ] No [ ] If No, date last attended _____

3. Has client been in special education classes? Yes [ ] No [ ]

4. Has client been sent home from school because of drinking or drug use? Yes [ ] No [ ]

5. Has client ever been suspended or expelled from school? Yes [ ] No [ ]

Why was client suspended or expelled? _____

_____

Is client in danger of being expelled now? Yes [ ] No [ ]

Why? _____

6. Is client having any other school problems? Yes [ ] No [ ]

A.	Speech disorder (e.g., lisp, stutter)	YES [ ] NO [ ]
B.	Learning problems in school	YES [ ] NO [ ]
C.	Grades	YES [ ] NO [ ]
D.	Truancy	YES [ ] NO [ ]

Comments: _____

_____

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B. FAMILY/RELATIONSHIP HISTORY:

I. Are client's biological parents still living together? Yes [ ] No [ ]

2. If parents are separated or divorced, with whom does client live? Mother [ ] Father [ ] other [ ]

If you checked "other", please list. Name(s): _____

Relationship: _____

3. Is client adopted? Yes [ ] No [ ]

4. Does client have children? Yes [ ] No [ ]

If so, how many? _____ Ages _____

C. LEGAL HISTORY:

I. Does Client have any charges pending? Yes [ ] No [ ]

If so, what are they? _____

2. Has Client had previous arrests? Yes [ ] No [ ]

If so what were the charges? _____

3. Being referred to Desert Visions by:

[ ] Aftercare Counselor [ ] Probation Officer [ ] Tribal Court [ ] Behavioral Health

[ ] County Court [ ] School [ ] Family Doctor [ ] Attorney [ ] Parent

4. Does Client have a Pending Court Hearing? Yes [ ] No [ ]

If yes, when is your court date? _____

5. Has Client been in treatment before for alcohol or drugs? Yes [ ] No [ ]

If yes, where? _____

6. Is the client under Child Protective Agency care? Yes [ ] No [ ]

If yes, what is the Child Protective Service plan? _____

_____

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D. MEDICAL PROBLEMS AND PHYSICAL CHALLENGES:

1. Is the client allergic to medications, foods, insect stings, plants? YES [ ] NO [ ]

If YES, what is client allergic to? _____

2. Asthma? YES [ ] NO [ ]
3. Diabetes? YES [ ] NO [ ]
4. Seizure Disorder? YES [ ] NO [ ]
5. Tuberculosis? YES [ ] NO [ ]
6. Heart Problems? YES [ ] NO [ ]
7. Hepatitis? YES [ ] NO [ ]
8. Other medical problems

_____

_____

9. What medications have been prescribed for the client? _____
10. Is the client pregnant? YES [ ] NO [ ]

If Yes, how many weeks pregnant? _____

Who is providing prenatal care for the client? _____

11. Is the client physically challenged? (For example, does the client use a wheelchair, crutches, cane or does the client have vision or hearing difficulties?) _____

E. EMOTIONAL/BEHAVIORAL:

1. Does the client have a history of an eating disorder? (Obesity or restrict food intake to keep weight dangerously low, or binge eat and then vomit or exercise to maintain weight?) YES [ ] NO [ ]

If YES, describe: _____

2. Does the client have a history of fire setting? YES [ ] NO [ ]

If yes, describe: _____

3. Does the client have a history of cruelty to animals? YES [ ] NO [ ] Describe: _____

_____

4. History of bedwetting? YES [ ] NO [ ]
5. Has the client been hospitalized for emotional/mental problems? YES [ ] NO [ ]

Hospital	Location	Dates of treatment	Reason for Admission

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6. Has the client seen a psychiatrist, psychologist, counselor or traditional healer for emotional/mental problems? YES [ ] NO [ ]

7. Does the client have a history of self-injury or suicide attempts? YES [ ] NO [ ]

Date: Method Name of Hospital # Days in Hospital Substance Abuse Involved?

_____

_____

_____

Additional information, re: suicide attempts, such as intervention/treatment: _____

_____

8. Is the client currently self-harmful or suicidal? YES [ ] NO [ ]

If YES, describe: _____

9. Does the client have a history of violence: YES [ ] NO [ ] If YES, describe: _____

_____

a. History of violence to self or others? (e.g. self-choking, etc.) YES [ ] NO [ ]
b. Has client been a victim of violence from others? YES [ ] NO [ ]
Describe: _____

10. Has the client been involved in a gang? YES [ ] NO [ ] If YES, which gang? _____

Gang colors & Attire: _____

Describe the client's involvement with the gang: _____

_____

Has Client used any of the following? (Please check)

___ Alcohol How much and how often: _____

___ Sedative Hypnotics/ tranquilizers (Valium, Librium, Miltown, Phenobarbital, etc.)

How much and how often: _____

___ Psychotropic (Stelazine, Cogentin, Thorazine etc.) How much and how often: _____

___ Barbiturates (Quaaludes. Phenobarbital, Nembutal, Tuinal, Seconal)

How much and how often: _____

___ Stimulants-amphetamines (Dexedrine, Crystal, Benzedrine, Methedrine, etc.)

How much and how often: _____

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___Sleeping pills If yes, what kind and how much/how often: _____

___Opiates (heroine, morphine, opium, etc.) Specify and how much/how often:_____

___Pain killers (Darvon, Darvocet, codeine, etc.) Specify and how much/how often :_____

___Hallucinogens (LSD, STP, MDA, PCP, mescaline, etc.)

Specify and how much/how often:_____

___Cocaine If yes, how much/how often:_____

___Cannabis (Marijuana) If yes, how much/how often:_____

___Steroids Specify and how much/howoften:_____

___Tobacco: Smoking [ ] How much/How often:_____

Chewing [ ] How much/How often: _____

___Caffeine: (Coffee, Soda) How much per day? _____

___Inhalants (Glue sniffing) If yes, how much/how often:_____

___Other Type: _____ How much and How often:_____

Has the client had withdrawal or severe hangovers in the past? YES [ ] NO [ ]

If YES, which substances caused withdrawal or severe hangovers _____

_____

Has the client had Blackouts? YES [ ] NO [ ] If yes please explain

_____

_____

Has the client had residential treatment for Substance Abuse? YES [ ] NO [ ]

Residential Facility Dates of treatment If NOT successfully completed, WHY?

_____

_____

Has the client had outpatient treatment for Substance Abuse? YES [ ] NO [ ]

Outpatient Program Counselor Dates of treatment If not successfully completed, why?

_____

_____

_____

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F. Other Issues the Client may need help with:

1. Delinquent (arrested or referred to juvenile court) YES [ ] NO [ ]
2. Run away YES [ ] NO [ ]
3. Juvenile Detention YES [ ] NO [ ]
4. Depression YES [ ] NO [ ]
5. Stealing YES [ ] NO [ ]
6. Possession of weapons YES [ ] NO [ ]

G. TREATMENT ACCEPTANCE/RESISTANCE

Is the client willing to come to treatment voluntarily? YES [ ] NO [ ]

H. RECOVERY ENVIRONMENT

1. Who currently lives in the home with the client? (list names, ages and relationship to client)

_____

_____

_____

2. Is there anyone currently living in the client's home who is in poor health? YES [ ] NO [ ]
   If YES, describe condition: _____

3. Is there anyone currently living in the client's home who is an active substance abuser? YES [ ] NO [ ]
   If YES, relationship and substance abused: _____

4. Is there anyone currently living in the client's home who is active in a program of recovery? YES [ ] NO [ ]
   If YES, relationship and circumstances: _____

5. Does the client have access to an Aftercare Program? YES [ ] NO [ ]
   If yes, what organization and contact person? _____

_____

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PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
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6. What are the current plans for the client after treatment?
   Living Situation: _____
   _____
   School Work: _____
   _____
   Aftercare Program: _____
   _____
7. What is the family expectation of the client? _____
8. Family strengths: _____
   _____
9. Family Liabilities: _____
10. Additional Information: _____
    _____
    _____
11. Diagnoses:
    (Include Substance Abuse and Mental Health problems. Must be completed by credentialed or licensed provider)
    Axis I _____
    Axis II _____
    Axis III _____
    Axis IV _____
    Axis V: GAF _____
12. Explain why Outpatient Treatment is not sufficient at this time: _____
    _____
    _____
    _____
    _____

_____ _____
Print Name of Licensed Provider/Title Date

_____ _____
Signature of Licensed Provider / Title Date

Phone: _____

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PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
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Desert Visions Youth Wellness Center

What to Bring to Treatment
Inventory Check List (Males)

Clothing: Absolutely NO gang colors or lettering: No alcohol/drug/gambling-related logos or any clothing.

____ Jacket & Sweater for camping and mountain climbing
____ Sweatshirt
____ 7 Shirts or T-shirts, White. (Plain, no lettering or pictures) (No tank-top T shirts)
____ 7 Pair jeans or slacks that fit – Not over sized.
____ 2 Pair sweat pants
____ Athletic shoes: (and hiking boots if you have them) 2 pair only.
____ Shower shoes: (flip-flops)
____ 7 Pair socks
____ Swimming trunks
____ 7 briefs or boxers
____ Pajamas
____ Bathrobe
____ Slippers
____ Caps: (to wear only for hiking or outdoor outings) must be plain.

Personal Hygiene:

____ Toothbrush/toothpaste/floss: (No mouthwash containing alcohol)
____ Shampoo/conditioner
____ Deodorant: (non-aerosol)
____ 4 Bars soap
____ Hand/body lotion

DO NOT bring cologne or hair spray or gel containing alcohol.

Personal Care:

____ Medication (Prescribed only – a physician's order is required).
____ Over the Counter Acne Medications (i.e., Proactive Solution)

Money, Valuables & Other:

____ No more than $20.00 for personal items for your child. You may add to it during your child's treatment. Desert Visions provides for expenses for special events and activities.
____ Stationery-stamps
____ Small portable am/fm radio, must have earphones (bring own batteries).

"NO NO's": Do NOT bring belts, cameras, cell phones, Ipods/Mp3 players, portable CD/DVD players, hand-held game systems, jewelry (including earrings and watches), pillows, blankets, towels, stuffed animal, sunglasses, food, gum, candy, weapons of any kind, or anything of value. Your money will be kept in a locked safe; you may request your money with approval of the Treatment Team. Alcohol, other drugs and tobacco products are NOT allowed.

Thank You

This Sheet may be torn from packet and given to client's family

Desert Visions Youth Wellness Center

What to Bring to Treatment
Inventory Check List (Females)

Clothing: Absolutely NO gang colors or lettering: No alcohol/drug/gambling-related logos on any clothing.

____ Jacket & Sweater for camping and mountain climbing
____ Sweatshirt
____ 7 Shirts or T-shirts, white – No tank tops or tube tops (no lettering or pictures).
____ 7 Pair jeans or slacks that fit – Not oversized. (During spring and summer, shorts are allowed, but
____ 2 Pair sweat pants no "Short shorts" and no Cut-offs)
____ Athletic shoes: (and hiking boots if you have them) 2 pair only. No clogs or sandals.
____ Shower shoes: (flip-flops)
____ 7 Pair socks
____ Swimming suit (1 piece) (No low or high cuts)
____ 7 Briefs or panties (no thongs)
____ 3 Bras (recommend sport bras)
____ Pajamas
____ Bathrobe
____ Slippers
____ Knee-length dresses/skirts/dress shoes

Personal Hygiene:

_____ Toothbrush/toothpaste/floss: (No mouthwash containing alcohol)
____ Shampoo/conditioner
____ Deodorant: (non-aerosol) (DO NOT bring perfume)
____ 4 Bars soap: (Ivory or non perfumed hypoallergenic soap)
____ Hand/body lotion
____ Tampons/maxi-pads/panty liners

DO NOT bring cologne or hair spray or gel containing alcohol.

Personal Care:

____ Medications (Prescribed only – A copy of physician's order is required)
____ Over the Counter Acne Medications (i.e., Proactive Solution)

Money, Valuables & Other:

____ No more than $20.00 for personal items for your child. You may add to it during your child's treatment.
Desert Visions provides for expenses for special events and activities.
____ Stationery-stamps
____ Small portable am/fm radio, must have earphones (bring own batteries).

"NO NO's": Do NOT bring belts, cameras, cell phones, Ipods/Mp3 players, portable CD/DVD players, hand-held game systems, jewelry (including earrings and watches), pillows, blankets, towels, stuffed animal, sunglasses, food, gum, candy, weapons of any kind, or anything of value. Your money will be kept in a locked safe; you may request your money with approval of the Treatment Team. Alcohol, other drugs and tobacco products are NOT allowed.

Thank You

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Desert Visions Youth Wellness Center

Transportation Form

To be Completed and Signed by, Parent/Guardian and a Witness.

I, _____, parent/guardian/referral accept full responsibility for the return transportation of _____, if accepted into treatment at Desert Visions Youth Wellness Center.

_____ Date _____
Parent/Guardian Signature

_____ Date _____
Witness Signature

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Desert Visions Youth Wellness Center

Consent for Client Treatment

To be Completed and Signed by the Client Parent/Guardian and a Witness

Client Name _____ DOB _____

Clients who are admitted for residential treatment for substance abuse and other problems may undergo the following evaluations, assessments and treatment services.

Evaluation and **assessment** may include, but are not limited to:

a. Substance Abuse History
b. Biopsychosocial History
c. Cultural/Spiritual Assessment
d. Medical History and Physical Exam (if not completed prior to admission)
e. Nursing Assessment
f. Psychiatric Assessment
g. Psychological Assessment/Testing
h. Educational Assessment
i. Art Therapy Assessment
j. Recreational Assessment

Depending on the needs of the client, treatment may include but is not limited to the following:

a. Group, individual and family therapy
b. 12-Step Meetings
c. Alcohol and drug information
d. Native American cultural and spiritual education and awareness (such as client research about their tribal heritage, singing, drumming, cultural arts and participation in the Sweat Lodge).
e. Dental/Medical care (prescription medications, over the counter medications), immunizations.
f. Academic Instruction
g. Art instruction and art therapy
h. Behavior modification and behavioral contracts
i. Outings and camping experiences
j. Ropes course

I, _____ agree to cooperate and participate in my evaluations.
Print Client Name

_____ _____
Client Signature Date

Consent is hereby given to Desert Visions Youth Wellness Center to provide evaluation, assessments and treatment for the above named client.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

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PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
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Desert Visions Youth Wellness Center

Consent to Photograph and Film Client

I, _____, hereby give my consent for Desert Visions Youth Wellness Center
(Print Client Name)
to take and use photographs, slides, or films of myself as part of the treatment process.

I understand that I have the right to be protected under the Federal Confidentiality Law and I do give my permission freely and of my own accord.

If no date of revocation is specified, this consent shall expire 1 year from the date of signature below.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

Revoke Date: _____

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<tr><td colspan="3">This information is to be released for the purpose stated above and may not be used by the recipient for any other purposes. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a(i)(3)). In the case of alcohol and drug abuse patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31(d).</td></tr>
<tr><td rowspan="3">PATIENT IDENTIFICATION</td><td>NAME (First, M.I. Last)</td><td>RECORD NUMBER</td></tr>
<tr><td colspan="2">ADDRESS</td></tr>
<tr><td>CITY/STATE</td><td>DATE OF BIRTH</td></tr>
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Desert Visions Youth Wellness Center

Consent for Client to Participate in Outings & Wilderness Experiences

Outings

An important part of the Desert Visions treatment program is the outings, which allow the client to explore the world outside the treatment center while clean and sober.

Outings are off site activities that may include, but are not limited to the following: 12-Step Meetings, visits to museums, libraries, churches, college campuses, parks, movie theaters, or other forms of wholesome entertainment. Off site activities may also be planned to promote full participation in Aftercare; clients may tour outpatient counseling programs, or facilities which provide residential treatment or educational or job training opportunities.

Wilderness Experiences

The clients may also have an opportunity to go on wilderness outings to challenge themselves and build self-confidence. Client activities may include, but are not limited to, hiking, riding horses, back-packing, rock climbing, overnight camping, and swimming, Ropes Course, building fires, and cooking.

Extensive precautions are taken to ensure that the wilderness outings are safe.

I, _____, agree to participate fully in outings and wilderness
(Print Client Name)
experiences as a part of my treatment at Desert Visions Youth Wellness Center.

_____ _____
Client Signature Date

****

I hereby give my consent for _____ to participate in outings
(Print Client Name)
and wilderness experiences with the staff from Desert Visions Youth Wellness Center.

_____ _____
Parent Guardian Signature Date

_____ _____
Witness Signature Date

Desert Visions Youth Wellness Center Client Agreement

Client Agreement

To Be Completed and Signed by the Client/Parent/Guardian and a Witness

During my treatment at Desert Visions Youth Wellness Center,

I, _____ agree to the following:

1. To take part in my treatment and to be on time for all activities.
2. To practice Honesty, Openness and work on a Willingness to change.
3. To allow Desert Visions staff to search my belongings and conduct a search for alcohol/drugs or other contraband upon admission and at any time that may be considered necessary by Desert Visions staff.
4. Not to bring alcohol/drugs to the treatment facility and I agree not to accept alcohol/drugs that may be brought to me.
5. Not to use alcohol/drugs except prescribed medications administered with the supervision of professional staff.
6. To provide a urine specimen for a Urine Drug Screen anytime upon request.
7. To meet and talk with my counselor and other staff as needed.
8. To stay on the treatment center grounds unless accompanied and supervised by staff.
9. To maintain the confidentiality of other clients. I agree not to take their pictures or reveal their names or confidential information to anyone outside the treatment center.
10. Not to engage in sexual activity.
11. To treat other clients, staff and property with dignity and respect.
12. To be cooperative and take part in my treatment and aftercare plans.
13. To perform and participate in community service activities at Desert Visions.

I understand that all the above statements are to help me in my treatment and to help me with my recovery and sobriety. I also understand that failure to follow these agreements may lead to my discharge.

_____ _____

Client Signature Date

I agree to be supportive and involved in my child's treatment (including the family program: Circle of Strength) as necessary.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Signature Date

Desert Visions Youth Wellness Center

Consent to Photograph and Film Client's Artwork

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, _____, hereby give my consent for Desert Visions Youth Wellness Center to take and use photographs, slides or films of my anonymous artwork as part of the treatment process and staff training.

I understand that I have the right to be protected under the Federal Confidentiality Law and I do give my permission freely and of my own accord.

I understand that I may revoke this consent for release of information at any time.

However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.

If no date of revocation is specified, this consent shall expire one (1) year from the date of signature below.

_____ Date _____
Client Signature

_____ Date _____
Parent/Legal Guardian Signature

_____ Date _____
Witness Signature

<table>
<tr><td colspan="3">This information is to be released for the purpose stated above and may not be used by the recipient for any other purposes. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a(i)(3)). In the case of alcohol and drug abuse patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31(d).</td></tr>
<tr><td rowspan="3">PATIENT IDENTIFICATION</td><td>NAME (First, M.I. Last)</td><td>RECORD NUMBER</td></tr>
<tr><td colspan="2">ADDRESS</td></tr>
<tr><td>CITY/STATE</td><td>DATE OF BIRTH</td></tr>
</table>

HEALTH INSURANCE INFORMATION

HEALTH CARE BENEFITS

Is the client covered by a Private Health Insurance Plan? Yes [ ] No [ ]

If yes, name of the plan _____

Policy # _____ Please include a copy (back & front side) of your insurance card.

Does this plan include residential substance abuse treatment? Yes [ ] No [ ] Unknown [ ]

STATE MEDICAID HEALTH PLANS

Is the client currently enrolled in AHCCCS or another state Medicaid plan? Yes [ ] No [ ]

If yes, what state _____ and Medicaid # _____

If Arizona, what is the AHCCCS # _____

ARIZONA RESIDENTS ONLY:

In the event the client is not covered by a private health insurance plan and is eligible for enrollment in the Arizona Health Care Containment System (AHCCCS), does Desert Visions have your permission to apply for AHCCCS health care benefits for the client? Yes [ ] No [ ]

If no, please state the reason _____

_____

AUTHORIZATION TO FURNISH INFORMATION

I authorize the release of information concerning the health care provided to the client,

_____ at Desert Visions Youth Wellness Center, to any and all Third Party Payers (i.e. AHCCCS, private health insurance) for the payment of services provided to the client. This authorization covers the entire treatment stay at Desert Visions Youth Wellness Center.

_____ _____

Parent/Legal Guardian Signature Date

Desert Visions Youth Wellness Center

Consent for Hair Cuts

I, _____, hereby give my consent for _____
(Print Parent Name) (Print Client Name)

to obtain hair cuts while in the care of Desert Visions Youth Wellness Center.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purposes. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a(i)(3)). In the case of alcohol and drug abuse patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31(d).

PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

Desert Visions Youth Wellness Center

Approved List of Client Contacts

Client Name: _____ Date: _____

NOTICE

In order to protect the confidentiality of clients and maintain a therapeutic milieu, only family members aged 18 years and older, will be allowed to contact the client.

Approved Client Contact List
(Immediate Family List)

Name	Age	Relationship to Client	Area Code & Phone #

Emergency Client Contact List

Name	Age	Relationship to Client	Area Code & Phone #

I approve of the above list of emergency contacts and other client contacts.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purposes. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a(i)(3)). In the case of alcohol and drug abuse patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31(d).

PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

DESERT VISIONS YOUTH WELLNESS CENTER

Consent Regarding Contact

If we cannot reach you regarding an issue with your child we may ask an agency in your community to help us locate you. This includes asking for help from a case manager (aftercare), a public health nurse, or local law enforcement.

By signing this agreement I state that I understand that I must keep Desert Visions aware of **HOW TO REACH ME AT ALL TIMES**.

Parent/Guardian:_____ Date:_____

Current Contact Information: _____

Other Contact Information: _____

By signing this agreement I give you permission to contact the case manager (aftercare), a public health nurse, or local law enforcement **IF YOU CANNOT CONTACT ME**.

Parent/Guardian: _____ Date: _____

Witness: _____ Date:_____

DESERT VISIONS YOUTH WELLNESS CENTER

Addresses Needed for Release of Information Forms

Please provide the addresses and phone numbers for the following agencies- specify individuals for each site.

This information will be placed on our Release of Information forms for the guardian to sign at intake.

Aftercare Counselor: _____

_____
Address

_____
City/State/Zip Code

_____
Phone Number

Behavioral Health Provider: _____

_____
Address

_____
City/State/Zip Code

_____
Phone Number

Applicant's Probation Officer: _____

_____
Address

_____
City/State/Zip Code

_____
Phone Number

Applicant's School: _____

_____
Address

_____
City/State/Zip Code

_____
Phone Number

History and Physical Examination

To be completed by a Licensed Physician, Physician's Assistant, or Nurse Practitioner.

Patient
Name_____Date_____

Date of Birth _____Tribal Affiliation_____

Chief Complaint:
1. The patient needs a complete History and Physical examination within one (1) month of admission to Desert Visions Youth Wellness Center.

Target admission date is _____

2. Current Medical Problem(s).

Current Medications and Doses.

Substance Abuse History

Nicotine Use(Smoking/Chewing Tobacco)

Past Medical History

Medical: HIV Tested? _____ Yes _____ No Date & Results _____

HIV Risk Factors: (Circle + Factors) IV Drug Use Unprotected Sex Blood Transfusion

If patient is sexually active, are condoms routinely used? _____ Yes _____ No

History of Hepatitis? _____ Yes Type of Hepatitis: _____

Other _____

Allergies _____

Hospitalizations:_____

Surgical: _____

Injuries: _____

OB-GYN: Menarche: _____ Menstrual History/Problems:_____

LMP:_____ Last PAP_____Gravida_____ Para _____

Contraception Used: _____

Other: _____

Family History:
Medical: _____

Psychiatric:

Review of Systems:

Physical Examination:

Vital Signs: _____P _____T _____R _____ BP
_____ Ht _____Wt

General: _____

Speech Impairment: _____ Yes _____ No Describe _____
Vision: _____ Left _____ Right
Hearing: _____ Left _____ Right

HEENT:
Head:
Eyes:
Ears:
Nose:
Throat:
Teeth/Gums:
Neck: Thyroid: Nodes:_____

Chest:
Breasts:
Lungs:
Cardiovascular: Heart: Pulses:

Abdomen:
Back/Spine:
Extremities:
Genitalis: (females - Pelvic)
Rectum:
Skin/Hair/Nails:

Neurological:
Cranial Nerves II - XII
Motor Strength
Cerebellar
Gait _____
Finger to Nose, Heel to Shin
Deep Tendon Reflexes:
Sensation:

Immunizations & PPD

_____ Immunizations: Please attach a copy of patient's up-to-date immunization record containing the following:

- _____ DPT (Diphtheria, pertussis, tetanus)
- _____ OPV (Polio, oral)
- _____ HIB (Bacterial meningitis)
- _____ MMR (Measles, mumps, rubella)
- _____ Td (Tetanus/adult diphtheris)
- _____ HBV (Hepatitus B)
- _____ Varicella zoster virus (chicken pox)
- _____ MCV4
- _____ Tdap

_____ PPD TB test. Please attach a copy of patient's **PPD results done within the past year.**
_____ Labs Please attach a copy of any recent labs.

Assessment and Plan:
Medical Diagnosis:

Plan:

Notes: Patients will be in treatment four months. Please schedule other critical appointment before or after treatment.

Physical Restrictions: None Yes Describe _____

Patient is stable for treatment at Desert Visions Youth Wellness Center: (circle one) Yes No

_____
Medical Provider's Signature Date PRINT Medical Provider's Name and Degree

Name of Clinic/Facility
Mailing Address:
City, State, Zip
Phone # FAX #
Clinic/Facility Accredited Yes or No.
If Yes, List accrediting organization:_____

For Use by Desert Visions Staff:
This PE was reviewed by
_____Date_____
See note in client chart.