Administrative Offices
715 S.W. Ramsey Ave., Grants Pass, OR 97527
(541) 474-5579 Fax (541) 541-476-7410

KAIROS

The moment when change is possible

INSTRUCTIONS FOR MAKING A REFERRAL FOR RESIDENTIAL RESPITE

To make a referral during regular business hours, please call the Access Department at 541-474-5579 ext. 3108; after hours, please call the program directly at 541-476-3302 ext. 5 regarding bed availability. You will be asked for basic demographic and clinical information.

The program will fax you a referral packet. Please use only this paperwork to ensure that you have the most current forms.

It is important for the legal guardian to understand the following:

- Respite stays are typically 3-5 days depending on what is authorized by the county
- Psychiatric services, including medication management, are not included unless specifically authorized by the county
- The program is not a locked facility

Please note that KAIROS does not provide transportation to or from the program.

The parent/legal guardian **must** sign admitting papers before admission, either by being present at admission or by filling out paperwork, faxing it to the program, and sending **original signatures** with the youth. Remind parent/legal guardian to bring all medications and clothing for the youth. The following is a complete list of all admitting paperwork needed and who is responsible for completing it.

Form	Parent/Legal Guardian	MH Crisis Worker/ County Representative	Authorized Designee
Admission Consent & Release Form (8 pages)			
Authorization for Release of Information (Schools, Physicians, Counselors, Mental Health Agencies)			
Resident Personal Needs Plan			
Diet Instructions Form			
Brief Health History			
Provide Medical / Insurance Card or OHP number			
Residential Respite Service Authorization (3 pages)			
Referral Face Sheet and Referral Information Sheet			
Ensure all above forms are completed			
Ensure valid Medical or Insurance Card is faxed to program			

KAIROS REFERRAL FACE SHEET

Service Requested: ☐ Psychiatric Residential Treatment ☐ Psychiatric/Residential Respite ☐ TFC
☐ Day Treatment ☐ ICTS ☐ Young Adult Program ☐ Outpatient

Youth's Name: _____ **Date of Birth:** _____ **Referral Date:** _____

Gender: M / F **Marital Status: S / M / D / W** **County of Origin:** _____

Original Referral Source: _____ **Phone:** _____

Client's Legal Status: ☐ Ward of the State ☐ Voluntary ☐ Civilly Committed/TVA ☐ OYA **JJIS # :** _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Social Security Number: _____ **Race/Ethnicity:** _____ **Religion:** _____

Legal Guardian ☐ DHS ☐ OYA ☐ Other : _____ **Phone:** _____

Caregiver Name: _____ **Relationship:** _____ **Phone:** _____

Caregiver Address: _____

Client's Current Placement and Address: (if different) _____

_____

Client's Current School Placement _____ **Last Grade Completed** _____

Medicaid/OHP/Prime Number: _____ **MHO:** _____

Private Insurance: _____ **ID Number:** _____

Hep B Status: positive / negative date: _____ **TB Test Results:** Positive / Negative date: _____

SSI / SSD: ☐ Yes ☐ No **Advanced Directive:** ☐ Yes ☐ No **Mental Health Directive:** ☐ Yes ☐ No

TRAUMA HISTORY:

- ☐ Emotional abuse
- ☐ Exposure to domestic violence
- ☐ Neglect
- ☐ Physical abuse
- ☐ Sexual abuse

PREVIOUS BEHAVIORS:

- ☐ Animal Cruelty/Abuse
- ☐ Drug &/or Alcohol Involvement
- ☐ Runaway
- ☐ Sexual Aggression
- ☐ Violent Behaviors
- ☐ Developmentally Disabled
- ☐ Fire Setting
- ☐ Self Harm
- ☐ Sexual Reactivity

_____ Number of prior out-of-home placements

_____ Number of prior psychiatric hospitalizations

_____ Known or estimated IQ

AXIS I Diagnoses: _____ CGAS/GAF score: _____

Treatment Considerations (what does the team want this client to accomplish during his / her stay?):

_____

_____

_____

Referring Party (please print): _____ Phone: _____

Agency: _____ Date: _____

KAIROS

Intensive Treatment Service
Referral Information Form

To be completed by the referring Care Coordinator, or by a QMHP with knowledge of the child's condition.

Child's Name:_____ Date of Referral:_____

Name of person completing this form: _____

Agency: _____

Presenting problem; reason for request for services:

Description of individual's current behavior/function:

Description of mood; affect; thought processes:

Evidence/estimation of risk to self/other:

Provisional Axis I diagnoses:

Estimated CGAS: CASII Score:

Family Information:

Problems/strengths in current placement:

School function: ☐ On IEP ☐ Spec. Ed (< 50%) ☐ Spec. Ed (50- 99%) ☐ Spec. Ed (100%)

School Setting: ☐ Public School ☐ Private School ☐ Alternative School ☐ Home School

Name of last school attended: _____

Last Grade Completed: _____

What interventions have occurred thus far?

Current medications:

Note previous assessments/evaluations/reports *(please include with referral)*:

Specific assessment questions or treatment goals:

1.

2.

3.

4.

5.

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RESIDENTIAL RESPITE SERVICE AUTHORIZATION

Name of Youth _____ **DOB** _____

Name of Referral Worker _____ **County**_____

I/we the referring party hereby stipulate that the above-named youth meets Kairos' established admission criteria for Residential Respite Services

- ☑ The youth is between the ages of 11 & 17 years of age.
- ☑ The youth is medically stable and does not require immediate medical care in a hospital setting.
- ☑ There is no known ingestion of harmful substances or evidence of such ingestion. This includes drugs and/or alcohol.
- ☑ The youth is experiencing acute emotional or behavioral instability but **does not** require a locked setting or a level of psychotropic medication management which necessitates 24 hour nursing or physician care
- ☑ The youth's primary need is not detention or incarceration.

I am authorizing Kairos to provide services as designated below. Please initial by each service requested. Please see service component grid on next page to determine what services meet the needs of the youth.

_____ **Psychiatric Respite Care ($576.29/day)**

_____ **Regular Respite Care ($472.37/day)**

_____ **Secure Crisis Respite ($655.67/day, authorized daily)**

I understand that in signing below, I am guaranteeing that Kairos receives reimbursement for services provided at the rate quoted.

Estimated Length of Stay: _____

Authorized Payment Representative **Date**

KAIROS Representative **Date**

While we do not normally provide medical care during a residential respite stay, nor do we typically prescribe medication during these stays, provision must be made for the payment of medical costs in the event of an emergency. Please feel free to discuss with us your questions or concerns regarding these matters prior to your child's admission to the program.

Also, we do not dispense over-the-counter medications during a residential respite stay with the exception of the two medications listed below. If you will allow Kairos staff to dispense either of these, please initial next to the chosen pain/fever medication:

_____ Tylenol _____ Ibuprofen

All other over-the counter medications need to be provided by the parent or guardian for the facility staff to dispense as authorized.

My child is currently covered by the following medical insurance policy **(please fill out a release of information form for the insurance company):**

CCO Name **Group Number** **Identification umber**

If a client has private insurance, please note that admission must be processed by the Access Department during normal business hours, 8:30 am to 5:00 pm, Monday through Friday.

* I agree to accept financial responsibility for any emergency medical or other expense not covered by other medical insurance. Such expenses should be billed to the following address:

Name **Address** **City** **State** **Zip**

Parent/Guardian Signature **Date**

Service Components	Residential Respite	Psychiatric Respite without 1:1 services	Psychiatric Respite with 1:1 services
Typical length of stay	3-7 days	Up to 14 days	Up to 14 days
Who can authorize	Authorized County MH Representative	Authorized County MH Representative	Authorized County MH Representative
Observation and behavioral stabilization through client involvement within the therapeutic living environment.	✓	✓	✓
24 hour awake supervision; staff ratio 1:3	✓	✓	✓
Case assignment to an available QMHP	✓	✓	✓
Initial Risk Assessment and Plan conducted by QMHP or QMHA.	✓	✓	✓
On campus activities only	✓	✓	✓
Intensive evidence based therapeutic interventions	✓	✓	✓
Discharge instructions	✓	✓	✓
Phone case management for discharge planning	✓	✓	✓
Psychiatric assessment within 3 days	Requires additional authorization and expense	✓	✓
Weekly medication management	Requires additional authorization and expense	✓	✓
Discharge planning with youth, referral source, and parent or guardian for crisis debriefing, transition planning.	Conducted by phone	Conducted in person and/or by phone	Conducted in person and/or by phone
Comprehensive assessment (Only if stay is authorized and client is present for 21 days or more)		✓	✓
Family therapy around crisis		✓	✓
Individual therapy around crisis		✓	✓
Discharge summary		✓	✓
1:1 supervision			✓

KAIROS

Authorization for Release of Information

We can help you better if we are able to work with other professionals and organizations that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

I authorize Kairos to share information about:

Name: _____ D.O.B.: _____ ID #: _____

with the following individuals or agencies:

_____ _____

_____ _____

_____ _____

including records of: ***(Please initial each item)***

Family History: ___ Yes ___ No

Employment/Unemployment: ___ Yes ___ No

Educational Reports: ___ Yes ___ No

Alcohol/Drug Treatment: ___ Yes ___ No

Medical/Psychiatric Treatment: ___ Yes ___ No

Mental Health Services: ___ Yes ___ No

Other, as listed: _____

_____

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances. ___ Yes ___ No ***(Please initial)***

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified: _____

_____

_____

This permission is good until 180 days following discharge from all Kairos programs: _____ ***(Please initial)***

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

_____ _____

Parent or Guardian Date

_____ _____

Client Date

_____ _____

Kairos Representative Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document _____

Kairos Representative

Administrative Offices
715 S.W. Ramsey Ave., Grants Pass, OR 97527
(541) 474-5579 Fax (541) 541-476-7410

KAIROS

The moment when change is possible

Admission Consent and Release Form

Individual's Name: _____

D.O.B.: _____ Admission Date: _____

Request for Admission and Consent to Treatment

I/we, the undersigned, as the responsible party(ies), hereby request admission of the above named child to Kairos, and consent to his/her care and treatment as recommended and provided by the Care Team.

_____ _____
Individual Date

_____ _____
Parent or Guardian Date

_____ _____
Kairos Representative Date

Agreement to Participate in Treatment and Aftercare Planning

I/we, the undersigned, as the responsible party(ies) hereby agree to participate in the treatment and discharge planning of the above named individual while s/he is in the care of Kairos.

_____ _____
Individual Date

_____ _____
Parent or Guardian Date

Voluntary Medical Consent

The legal status of my/our child, named above, at the time of signing this release is _____ _____. I/we, the undersigned, voluntarily authorize Kairos to provide health services for the above named individual as deemed necessary or desirable. This may include, but is not limited to, physical and mental examinations, ordinary medical, dental, psychiatric, psychological, hygiene and other remedial treatment, including immunizations (as well as seasonal vaccinations, i.e. flu) and the use of psychiatric medication. This does not delegate consent for abortion for those under 15, extraordinary or controversial medical or surgical procedures, any medical or surgical procedure to which the legal parent or guardian is opposed, or sterilization or any medical procedure, treatment or operation for the purpose of rendering the child permanently incapable of procreating.

☐ I do not give consent for seasonal vaccinations.

I wish to be informed about medication prescriptions or changes in medication:

☐ In writing immediately following any prescription or change in prescription.

☐ Before any prescription or change in prescription. I understand that choosing this option may result in delays in implementation of the prescription which could prolong my child's stay in the program.

☐ I give consent for routine urinalyses upon admission, and/or as needed, including screening for Sexually Transmitted Diseases such as Chlamydia and Gonorrhea as recommended by the County Health Department.

☐ I do not give consent to be screened for the above named STDs.

☐ I have an Advanced Health Directive to direct Kairos in making health care decisions for me should I become unable to do so. It is located at:

_____

☐ I have an Advanced Behavioral Health Directive to direct Kairos in making health care decisions for me should I become unable to do so. It is located at:

_____

☐ I do not have an Advanced Directive but would like information and assistance in creating one. Until one is created and signed by me, I hereby give Kairos permission to seek emergency medical treatment, such as surgery or other drastic treatment, for me in the event that I am unable to do so.

☐ I do not have an Advanced Directive and do not wish to establish one at this time. I understand that any time I determine that I would like to create one, a Kairos representative will be made available to help me do so.

Signature:

_____

I/we further authorize Kairos in an emergency, to give consent to extraordinary health care, such as surgery or other drastic treatment, when a qualified physician determines that there is an emergency and the health and welfare of this child warrants such extraordinary treatment.

I/we understand that I am responsible for payment of prescription medication or any other services not covered by or paid for by Medicaid or any insurance policy I may carry. I promise to keep the above named provider informed of our current address and telephone number for billing purposes.

I, by signing this document, confirm that I have carefully read, or have had someone carefully read to me and fully explain this Voluntary Medical Consent and that I understand what it says and have signed it for the best interests of this individual.

This consent may be revoked by me in writing at any time except to the extent that action has been taken in reliance hereon.

The consent is given voluntarily for the above stated purpose and will continue for as long as this individual remains at Kairos, expiring upon discharge.

Individual _____ Date _____

Parent or Guardian _____ Date _____

Kairos Representative _____ Date _____

Consent for Use of Restraint and Seclusion Procedures
(Residential / Day Treatment Programs Only)

I/we, the undersigned, understand that Kairos staff may at times be required to employ therapeutic physical hold techniques or seclusion in order to preserve the safety and security of residents. These procedures have been described to me/us. I/we agree that in the event the above named child/adolescent requires this level of intervention, staff may do so. I/we understand that I/we will be notified of each incident. I/we have been informed that I/we can discuss these procedures with clinical or administrative staff for further clarification of the techniques, circumstances and reasons at any time.

In addition, New Beginnings utilizes video surveillance to ensure the safety of our clients and staff. The cameras are only used I common areas, not private areas such as bedrooms and bathrooms.

Individual _____ Date _____

Parent or Guardian _____ Date _____

Kairos Representative _____ Date _____

Consent for Drug Screening

I/we, the undersigned, as the responsible party(ies), hereby grant permission for drug/toxicology screening of the above named child while s/he is in Kairos.

Individual _____ Date _____

Parent or Guardian _____ Date _____

Kairos Representative _____ Date _____

Field Trip and Excursion Trip Consent

I/we grant permission for the above named individual to participate in supervised field trips, excursions and off campus group recreational activities, as planned and implemented by Kairos staff.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Swimming Activities

I/we grant permission for the above named individual to participate in supervised swimming activities.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Consent for Photograph

Per the Join Commission, a photograph of the above named individual will be obtained upon admission for electronic records completion.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Consent for Client Audio Recording

I/we grant permission for the above named individual to have Collaborative Problem Solving sessions audio recorded for the purpose of training and education, not limited to: feedback from Massachusetts General Hospital in honing our skills in the Collaborative Problem Solving Method.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Consent for Haircuts (New Beginnings Program Only)

Staff at the Merlin facility routinely provides haircuts to residents. Your permission is required in order for your child to participate in this activity.

I/we, the undersigned, authorize Kairos staff to provide a haircut for the above named child.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Tours and Volunteers Consent
(Residential / Day Treatment Programs Only)

I/we understand that individuals from the community may enter the treatment milieu in the context of tours and volunteer work projects. I/we understand that when possible staff will let residents know in advance about these visitors, and that they may request not to be seen, and staff will make it possible for them to be away from the group to protect their privacy.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Unanticipated Events
(Residential / Day Treatment Programs Only)

I / we understand that due to the fact that my child will be exposed to a variety of children and behaviors, he/she may mimic some bad habits that has been witnessed (i.e. cursing, teasing, property damage, etc). Kairos staff will continue to explain and teach children that these types of behaviors are not acceptable.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Dress Code Consent

I / we, the undersigned, understand that the above named youth is expected to wear clothing that is non-revealing and does not depict negative messages or imagery. Kairos reserves the right to impose a dress code, as deemed necessary.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Documentation/Availability of Materials

Upon request, written materials may be provided in another language, as well as Braille, tape, or other alternatives. Please sign below if you wish to have materials presented in an alternative format.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Format Requested:

Preferred Language:

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users). USDA is an equal opportunity provider and employer.

KAIROS Brief Health History

In order to provide appropriate medical care if it is needed, please complete the following information about this youth's health status/history. Please complete as much information as you know about the following.

All areas must be completed for respite admissions and outpatient.

Name of current Physician: _____

Location? _____ Date of last visit: _____

Does this youth have any food or environmental allergies? ☐ no ☐ yes

Please list and note what type of reaction occurs:

_____

_____

Is this youth allergic to any medications? ☐ no ☐ yes

Please list and note what type of reaction occurs:

_____

_____

Does this youth carry an Epi-Pen for allergies? ☐ no ☐ yes

_____

_____

Is this youth taking any medications? ☐ no ☐ yes Please list:

_____

_____

Youth name_____ DOB: _____

Is this youth diabetic? ☐ no ☐ yes

Does this youth have any chronic medical conditions (ie: epilepsy) ☐ no ☐ yes

Please describe: _____

_____

_____

Please list any identifying marks (i.e. birthmarks, piercings, tattoos, etc.):

_____

_____

_____

KAIROS Brief Health History

Use of drugs, alcohol or tobacco by this youth – check any that apply & give further explanation when needed

☐ to my knowledge this youth has not used street drugs, alcohol or tobacco
☐ this youth has used alcohol- how much?_____
☐ this youth has used street drugs- list type and how much_____
☐ this youth has used tobacco- list type and how much_____

Date of last use of any of the above substances: _____
Please specify:

_____

_____

_____

Does the youth have a history of self harm or attempted suicide? ☐ no ☐ yes

Please list the date(s) and describe:

_____

_____

_____

_____

_____

_____

Do you have any other health concerns regarding this youth? Please explain:

_____

_____

_____

_____

_____

_____

Name of Person Completing this form (please print): _____

Relationship to youth: _____

Signature: _____ Date: _____

Client Name:

CLIENT CONTACT LIST

We ask that the legal guardian assist us in identifying & determining your youth's needs & privileges in the areas of contact with others &/or in meeting cultural religious needs. You may request changes to any part of this plan at any time.

Emergency Contact / Legal Guardian

Legal Guardian(s) will be notified of incidents and emergency safety interventions

Name	Relationship	Phone Number	OK to leave detailed message?	I want to be contacted at time of incident, even if during sleeping hours (if no, we will call next morning)
			Y N	Y N
			Y N	Y N

CONTACT PRIVILEGES:

Name	Relationship	Phone Number	Allowed phone calls FROM	Allowed phone calls TO	Allowed to exchange mail	May visit with ON campus	May visit with OFF campus
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N

Religious/Cultural: Please identify any special needs, requests, or concerns

Signature of Legal Guardian Date Signature of Kairos Representative Date

THREE RIVERS SCHOOL DISTRICT
(541) 862-3111

KAIROS Psychiatric Residential Treatment Facility Schools
New Beginnings School (11-17 yr. olds) and Three Bridges School (17-24 yr. olds)
Leslie Clark, Special Education Teacher

Karen Porter, CEA / Registrar
711 Ramsey Ave., Grants Pass, OR 97527
Phone: (541) 479-5901 x1135
Fax: (541) 479-6329

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

TO: _____ **RE:** _____
Students Name

_____ **DOB:** _____

I hereby authorize the Three Rivers School District to obtain or release educational, psychological and medical information concerning my child. I understand that the information is for the confidential use of the professional personnel directly concerned with helping my child. (Three Rivers School Policy on Student Records 5700).

Please send the following information:

1. Current Transcript
2. Recent Report Card/Progress Report
3. 504 Documents (if any)
4. Statewide Assessments (OAKS) Scores
5. GED referral/materials (if applicable)

Special Education Records if any:

1. Current Evaluations
    a. With most recent Consent to Test
2. Eligibility Report
    a. With initial or most recent Consent for Provision of Services
    b. With Medical Statement and Rating Scales if applies
3. Most Recent IEP and Placement
4. Original Special Education Referral

_____ _____
Parent/Guardian/Adult Student or Authorized TRSD Signature Date

This authorization is issued in conformance with the policy of the Three Rivers School District.

Federal Law 99.31: No parent or student signature required for educational records sent to another educational agency.

Form 119-Kairos
Revised 3/13/2014

PRIOR NOTICE AND CONSENT FOR
DIAGNOSTIC PLACEMENT FOR EDUCATIONAL SERVICES
(INCLUDING SERVICES FOR SPECIAL EDUCATION STUDENTS ON AN IEP)
Three Rivers School District: Schools at New Beginnings and Three Bridges for KAIROS clients

Dear Parent or Guardian of _____,
Student's Name

Your student will receive education services while in residential treatment. Initially, this is a diagnostic placement, until records arrive from the previous school. The teaching staff requests your support in obtaining previous educational records in order to continue services in line with state and district standards; and based on your student's progress achieved to date. Please sign the release of student educational records attached.

While in our program students will have access to individualized instruction including online classes and tutorial support. The school supports the residential treatment program goals by providing daily observational assessments and participating in care team meetings. Informal testing to determine placement in classes and OAKS (Oregon Assessment of Knowledge and Skills) may occur while your student is in residence.

CONSENT FOR INITIAL DIAGNOSTIC PLACEMENT

☐ I give my permission for initial diagnostic placement as described above.

☐ I refuse consent for initial diagnostic placement as described above.

_____ _____
Signature (Parent/Guardian/Surrogate Parent or Adult Student Date

* Additionally, parents of a child with a disability have protection under procedural safeguards. For a copy of the procedural safeguards or for assistance in understanding this information contact: Leslie Clark, Special Ed Teacher, 541-476-3302 x3207

Home Language Survey: Please respond to the questions below.

1. What is the primary language spoken at home?
   - ☐ English
   - ☐ Spanish
   - ☐ Other (if other please specify) _____

2. What is the primary language of the student's biological parents?
   - ☐ English
   - ☐ Spanish
   - ☐ Other (if other please specify) _____

ADMISSION DIETARY INSTRUCTIONS

Name:_____ Client ID#:_____

❑ FOOD ALLERGIES (Please list):

Describe typical reaction if consumed:

Does the youth carry an Epi-Pen for this allergy? ☐ Yes ☐ No

❑ Regular diet

❑ Special diet:

Instructions:

Reason:

☐ **USDA Medical Statement submitted to Food Services for product substitution (grain,, milk, meat, cheese, egg, nut, legume, or dairy product).**

☐ **Half Portions**

❑ Potential food/drug interaction (describe):

_____ _____

LMP Signature Date

Food Services acknowledgement of receipt: _____

Initials/Date

Route: Hard Chart, Physician's Order Book, Kitchen

KAIROS

The moment when change is possible

Administrative Offices
715 S W. Ramsey Ave., Grants Pass, OR 97527
(541) 956-4943 Fax (541) 956-5463

Client Audio Recording Consent/Release

I hereby grant permission for _____
to be recorded by audio.

I recognize that this recording might be played at Collaborative Problem Solving trainings at Kairos. I give my consent for this audio recording to be used for the purpose of training and education, including but not limited to: feedback from Massachusetts General Hospital in honing our skills in the Collaborative Problem Solving Method.

_____ _____
Client Date

_____ _____
Guardian Date

_____ _____
Kairos Representative Date