Neurological Vocational Services Unit

INTAKE TRACKING FORM

Harborview Medical Center

Department of Rehabilitation Medicine

Dear Client: Please fill out your name, phone number, and how you heard about NVSU below. This form is used to track your intake appointment to ensure we can provide the best possible service and follow-up to you. Thank you.

_____

Last Name **First Name** **Middle Initial**

_____

Phone

How did you hear about Neurology Vocational Services?

(This Space For NVSU Use)

Counselor: _____

Date seen for intake: _____

Outcome of intake:

_____

_____

_____

NVSU Counselor: Please fill out, detach, and give this form to the Secretary Senior. Thank you.

Neurological Vocational Services Unit
INTAKE FORM

Harborview Medical Center
Department of Rehabilitation Medicine

Please read each part of this intake form and answer only those questions that pertain to you. At the end of each section is space for you to comment on anything else that you think would be important for us to know. Your answers and comments will help us understand how we can best serve you.

Harborview ID#: _____ Date: _____

_____
Last Name First Name Middle Initial

_____ _____ Female ___ Male ___ _____XXXX-XX-_____
Birth Date Age Today Last four of Social Security Number

_____
Street Address City

_____
State Zip Code E-mail Address

_____ _____ _____ _____
Cell/ Message Phone Home Phone Work Phone

In case of an emergency, whom would we contact?

Name _____ **Emergency phone number** ( )_____

What do you consider to be your PRIMARY disability?_

What is your HIGHEST level of completed education?_____

Have you received our services in the past? ___ No ___ Yes, How many times?_____

From whom did you find out about Neurology Vocational Services Unit?_____

Ethnic Group *(optional)*

___ African American ___ Caucasian ___ Asian/Pacific Islander

___ Latino ___ Native American ___ Other /Multi Racial

PHYSICAL STREET ADDRESS: 401 Broadway, Suite 2088 ~ Seattle, WA
Mailing Address only: 325 9th Avenue / Box 359744 ~ Seattle, WA 98104
Telephone: (206) 744-9130 / FAX: (206) 744-9988 Web: nvsrehab.org

Part 1

1. Do you speak English? ___ Yes ___ No What language(s) do you speak?

   Do you require an interpreter? ___ Yes___ No

2. Are there any cultural or diversity issues you would like for us to address?

3. Are you a Veteran? ___ No ___ Yes, What era did you serve? _____

   _____ Service _____ Rank _____ # Years of Service

   ___ I am a Disabled Veteran.

4. Have you ever been convicted of a felony, crime against people, or have a lawsuit pending?

   ___ No ___ Yes, Please describe: _____

5. Indicate the level of education you have completed and the diplomas you possess:

   ___ High School Diploma ___ GED ___ Other: _____

   Secondary Education: AA AS BA BS MA MS PhD Other _____
   (Technical, etc.)

   Years completed? _____ Where? _____

   Other vocational training/ on-thejob training? _____

6. Have you received special education for your condition?

   ___ No ___ Yes, Please describe: _____

   _____

7. Do you have access to internet services? ☐ Yes ☐ No

8. What is the level of your computer skills? _____

Part 2

1. Have you been diagnosed as having epilepsy? ___ No ___ Yes

   If "yes," complete the *"Seizure Disorder Information"* form)

2. Have you been diagnosed as having multiple sclerosis (MS)? ___ No ___ Yes

3. Have you been diagnosed as having a brain injury or head injury?

   ___ No ___ Yes, Date of injury: _____

4. If you have had a brain injury or head injury, were you in a coma?

   ___ No ___ Yes, Length of coma in: ____ days ____ hours ____ minutes.

5. Have you been diagnosed as having a stroke?

   ___ No ___ Yes, Date of stroke: _____

6. Please indicate any other neurological condition(s) that you have.

   ____ Encephalitis ____ Arteriovenous malformation (AVM)

   ____ Brain tumor ____ Meningitis ____ Cerebral Palsy

   ____ Anoxia (loss of oxygen to the brain) ____ Autism Spectrum Disorder

   ____ ADD/ADHD ____ Learning Disorder

   ____ Other: _____

7. Additional comments you wish to make:

Part 3

1. Do you have or have you had a mental health condition? ___ No ___ Yes

   What was the diagnosis or problem? _____

   Were you hospitalized for this condition? ___ No ___ Yes, Dates _____

   Did you receive other treatment for this condition? ___ No ___ Yes

   What was the treatment? _____ Are you still receiving treatment?

   ___ No ___ Yes

2. Do you desire counseling or psychotherapy?

   ___ No ___ Yes, ___ Now ___ Later

3. Have you had or do you have an alcohol or drug abuse problem? ___ No ___ Yes

4. Have you received treatment for alcohol or drug use?

   ___ No ___ Yes, Dates _____

   What was the treatment? _____

5. How many alcoholic drinks (beer, wine, or mixed) do you drink?

   ___ per day ___ per week

   Do you binge drink? ___ No ___ Yes, How often? _____

6. Do you use any recreational drugs/ medical marijuana (e.g., marijuana, cocaine, heroin, hallucinogenics, methamphetamine)? _____

7. How often do you use the drug(s)? ___ per day ___ per week

8. How often do you drink caffeinated drinks? What type (coffee, soda, etc.)? _____

9. How much sleep do you get per day (24 hours)? hours minutes

10. How much exercise do you get per week? hours minutes days per week

11. For follow-up services, please list the names of two people (parents, friends) who will always know how to contact you in the future:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Telephone (_____)_____

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Telephone (_____)_____

Part 4

1. Do you see a doctor regularly? ___ No ___ Yes

2. What type of doctor do you see?

   ___ Neurologist ___ Rehab Physician ___ General Practitioner Other: _____

3. Your Doctor's Name_____

   Address _____

   City _____ State _____ Zip Code _____

   Telephone (_____)_____

   Date of your last physical examination: _____

4. Other than the health issues covered in Parts 2, 3, and 4, do you have any additional medical problems? ___ No ___ Yes

5. In the categories below, please describe the other medical problems that you have and any medications that you take:

   Physical _____

   Sensory _____

   Emotional _____

   Mental _____

   Memory _____

   Other _____

6. Are you satisfied with your medical care? ___ No ___ Yes

7. Do you currently have health insurance? ___ No ___ Yes

Part 5

1. Do you have a driver's license? ___ No ___ Yes

2. How do you get around? ___ I drive only. ___ I use public transportation. Both.

3. What is your marital status? ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

4. Are you homeless? ___ No ___ Yes, Do you want housing? ___ No ___ Yes

5. Where do you live? ___ In a house ___ In an apartment ___ Other: _____

6. With whom do you live? ☐ Alone ☐ My parent(s) ☐ My brother/sister ☐ My in-laws
   ☐ My spouse ☐ My spouse and our children ☐ My children, Ages _____
   ☐ With roommates/friends, How many? ___ Other: _____

7. How many people are you financially supporting (including yourself)? _____

8. Are you currently supported by another family member or significant other?
   ___ No ___ Yes, What is that person's salary or hourly wage? $ _____

9. Identify the benefits program or public assistance you receive and the amount received:

Program or Assistance	Receive (X)	Amount per month
TANF / AFDC		
SSI (gold check)		
SSDI (blue-green check)		
Retirement		
Food Stamps		
Unemployment		
Medicaid / Medicare		
VA - Service Connected Disablity		
GAU (Public Assistance)		
Long-term Disability		
Short-term Disability		
Other_____		

Part 6

1. What is your employment status?

   ____ Employed ____ Unemployed ____ Underemployed ____ Retired

2. Are you working ____Part-time? ____Full Time? If yes: Hours per week _____

3. Do you volunteer? ____ No ____ Yes Hours per week _____

4. Do you enjoy your work or your volunteer position?

   ____ No ____ Yes Comments: _____

5. Number of jobs you have had in the last three years: _____

   Months since last job: _____ Longest job held # ____ Years ____ Months

6. What type of compensation do you receive for either your job or your volunteer position?

   ____ I don't receive compensation. ____ I receive free services in exchange for my time.

   ____ I receive a salary/wage. How much is your salary/wage? $_____

7. If you are not now employed, have you been employed in the past? ___ No ___ Yes

8. If you were employed before, why did you stop working? _____

9. Have you had prior contact with the Division of Vocational Rehabilitation (DVR)?

   ____ No ____ Yes

10. If you have had prior contact with DVR, what was the outcome?

    ____ I got a job. What was the job? _____

    ____ I received training. What was the training? _____

    ____ I dropped out of the program. Why?

11. Who was your DVR counselor? _____

12. If still active, who is your DVR counselor? _____

13. Have you ever requested a work accommodation for your disability? ____ No ____ Yes

14. If yes, please indicate the nature of the work accommodation(s) that you requested:

____ Modification of equipment ____ Installation of new equipment

____ Change in duties ____ Change in work schedule

____ Modification of physical facilities ____ Reassignment to another position

____ Reader ____ Other _____

15. How motivated are you to go to work now?

☐1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐1 0

16. By what date do you want to be working? _____

17. If you had a job offer, that was consistent with your job goal, could you go to work within the next 10 days? YES ☐ NO ☐

If no, please explain _____

Job History Form (A current resume may be used in place of this form)

From Month/Year To Month/Year	Company Name City and State	Volunteer Position Title	Paid Job Title	Hours/ Week	Wage/ Salary	

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The Joint Notice of Privacy Practices of UW Medicine and Certain Other Providers brochure describes how medical information about you may be used and disclosed, how you can get access to this information, and who to contact if you have questions, concerns or complaints.

We have a responsibility to protect the privacy of your information, provide a Notice of Privacy Practices, and follow the information practices that are described in this notice. If you have any questions, please contact: UW Medicine Privacy Office **1-866-964-7744**.

Please do not write comments on this form, refer to the "Notice for instructions on how to make special requests about your Privacy Rights.

We may change our policies at any time. Any significant policy change will be posted. You may request a copy of this notice from the UW Medicine Privacy Office 866-964-7744, or at www.uwmedicine.org

By signing below, I agree that I have received the Joint Notice of Privacy Practices of UW Medicine and Certain Other Providers.

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION)	DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIPTO PATIENT AND DESCRIPTION OF THEIR AUTHORITY

FOR OFFICE USE ONLY: REMARKS for the UW Medicine Notice of Privacy Practices:

(This section below is to be filled out by UW Medicine staff only)

We are unable to obtain acknowledgement from this individual at this time, but immediate treatment is needed for the following reason(s):

"√"	*Reason*	*Comments*

UW Medicine
Workforce Member
Signature: _____ Date: _____

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine Health System
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

U2045

UH2045 REV DEC 10

WHITE – MEDICAL RECORD
YELLOW – PATIENT

CARE AGREEMENT

This form contains facts you should know about your health care at UW Medicine and from Children's University Medical Group, University of Washington Dentists and Oral Surgeons, and Seattle Cancer Care Alliance. If there is any part of this form that is unclear you can ask questions about it. At the bottom of the form there is a place for you to sign your name so that we know you have read this form (or had it read to you) and agree to receive health care from us.

UW Medicine includes:

- University of Washington Medical Center and Clinics
- Harborview Medical Center and Clinics
- UW Medicine Neighborhood Clinics
- UW Physicians Sports Medicine Clinic
- UW Medicine Eastside Specialty Center
- Hall Health Primary Care Center, and
- UW Physicians

Your healthcare team consists of medical doctors, doctors who have completed medical school but are receiving additional training (residents and fellows), nurses, other healthcare professionals, and other health sciences students (for example, nursing students). They will work together to diagnose and treat you. You will have an attending physician. This is the doctor who has primary responsibility for your care.

Photographs, videotapes, or other images of you may be used to keep a record of your care and treatment (including surgery). These images may become part of your medical record.

SIGNATURE

By signing below, it shows that you have read this document and agree to receive health care from UW Medicine. If there is any part of this form that is unclear, be sure to ask questions about it.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/sister(s)

FOR MINOR PATIENTS:

☐ 1. Guardian/legal custodian ☐ 2. Court-authorized person for child in out-of-home placement ☐ 3. Parent(s)
☐ 4. Holder of signed authorization from parent(s) ☐ 5. Adult representing self to be a relative responsible for the minor's health

PT.NO

NAME

Place EPIC Label Within Box

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

CARE AGREEMENT

U0051

UH0051 REV JUL 07

WHITE – MEDICAL RECORD
YELLOW - PATIENT

CONSENT – GRAY

Neurological Vocational Services Unit
RELEASE OF INFORMATION

UW Medicine
Harborview Medical Center

Dear Client: Please enter your name and current address, sign, and date this letter of release.

To: **Neurological Vocational Services Unit**
Department of Rehabilitation Medicine
Harborview Medical Center
325 Ninth Ave. Box 359744
Seattle WA 98104

From: _____

_____

_____

_____

Neurological Vocational Services Unit is hereby authorized to release to prospective employers, or to other medical, mental health, rehabilitation, or other government agencies providing services on my behalf, any psychological or substance abuse information deemed assistive to my vocational rehabilitation or economic self-sufficiency.

_____ _____ _____

Signature **Date**

Neurological Vocational Services Unit
Harborview Medical Center

PARTICIPANT GRIEVANCE PROCEDURES

POLICY:

Participants have the right to file grievances to appeal enrollment decisions or to lodge other complaints regarding program services.

NVSU GRIEVANCE PROCEDURES:

1. **NVSU complies with the Harborview Medical Center Grievance Policy 5.14. Participants are encouraged to resolve issues and concerns informally with their Employment Specialist or Rehabilitation Counselor.**

2. **If the issue can not be resolved at this level, or the issue is unresolved it can be brought to the Director or Manager of NVSU. A written explanation of the complaint will be directed to the program coordinator for bi-annual review for program improvement purposes.**

3. **In the event the issue cannot be resolved informally, you can meet with the Director of the Vocational Services Unit to further discuss your concerns. This meeting will occur within two weeks from the date a written request is received by the Director. The written results of this meeting will be made available within two weeks to you, the Director, and the sponsoring agency, when appropriate. Complaints can also be directed to the Patient Relations Manager at Harborview Medical Center. Contact Info M-F: 8 a.m. to 5 p.m. Location: 1 EH 99 Box 359942 phone: 206-744-5000 fax: 206-744-4114. Additional information can be located in the "Joint Notice of Privacy Practices" pamphlet that you received at the beginning of your services with NVSU.**

CLIENT ASSISTANCE PROGRAM PROCEDURES:

The Client Assistance Program is available to help people who are applying for or receiving services that are funded by the federal Rehabilitation Act of 1973 (as amended). In Washington, this includes the Washington Division of Vocational Rehabilitation, Independent Living Centers, and Project With Industry. If you desire assistance or would like to lodge a complaint regarding one of these services, simply call: (206) 712-5999 (voice or TDD), or 1-800-544-2121 (V/TDD).

I verify that I have received a copy of the above grievance procedures.

SIGNATURE _____ DATE _____

FILE COPY (Signed)

Neurological Vocational Services Unit
Harborview Medical Center

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I verify that I have received a copy of the above grievance procedures.

CLIENT'S COPY. (Signed copy on file.)

Neurological Vocational Services Unit
Harborview Medical Center

PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

RIGHTS.

You have the right to:

Be treated in a respectful, ethical and professional manner.

Be treated as an individual with unique needs.

Receive services in a timely and efficient manner.

Participate fully through informed choice in development and implementation of placement plan.

Review/modify your plan at any time.

Be actively engaged in job seeking activities as fully as possible.

Have confidentiality of personal and medical information maintained.

RESPONSIBILITIES.

You are expected to:

Attend scheduled meetings or call if you are unable to attend.

Perform job seeking and follow up activities as indicated in the placement plan.

Dress appropriately and demonstrate appropriate hygiene.

Maintain communication on a regular agreed upon during placement plan development.

Provide employment data from time of hire through 1 year of employment.

I verify that I have received a copy of the above rights and responsibilities.

SIGNATURE _____ **DATE** _____

FILE COPY (Signed)

Department of Rehabilitation Medicine
University of Washington

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CLIENT'S COPY. (Signed copy on file.)

Part 10

Intake Notes: **Staff Initials _____ Date _____**

Part 2a: Seizure Disorder Information

Please complete this section only if you now have epilepsy or seizure activity.

Type of seizures (check each that applies):

☐ Tonic Clonic (grand mal) (date of most recent seizure: _____)
Frequency: _____ per ☐ day ☐ week ☐ month ☐ year

☐ Partial Complex Seizure (psychomotor) (date of most recent seizure: _____)
Frequency: _____ per ☐ day ☐ week ☐ month ☐ year

☐ Absence (petit mal): (date of most recent seizure: _____)
Frequency: _____ per ☐ day ☐ week ☐ month ☐ year

☐ Seizure not clearly diagnosed: (date of most recent seizure: _____)
Frequency: _____ per ☐ day ☐ week ☐ month ☐ year

☐ Other (identify, if known: _____)
(date of most recent seizure: _____)
Frequency: _____ per ☐ day ☐ week ☐ month ☐ year

About your seizures:

1. Which of the following do you experience when you have a seizure? (Check all that apply)
   - ☐ I walk around, but I am not aware of myself or my surroundings
   - ☐ I am not myself for more than _____ minutes
   - ☐ I have a partial loss of consciousness
   - ☐ I have a complete loss of consciousness
   - ☐ I cry or shout
   - ☐ I stare
   - ☐ I get a warning aura
   - ☐ I fall down if I am standing
   - ☐ I become aggressive
   - ☐ I have repetitious movements
   - ☐ I require supervision
   - ☐ I bite my tongue
   - ☐ I drop objects I am holding
   - ☐ I have sudden, jerking movements
   - ☐ I lose bowel control
   - ☐ I lose bladder control

2. If you have warnings or auras before a seizure, how often do they appear?
   ☐ Sometimes ☐ Always How long before a seizure? _____

3. Which of the following might precipitate or start your seizure activity
   - ☐ Blinking or bright lights
   - ☐ Boredom
   - ☐ Menstruation
   - ☐ Use of alcohol or drugs
   - ☐ Emotional upset
   - ☐ Physical exertion or fatigue
   - ☐ Certain noises; describe: _____
   - ☐ Certain smells; describe: _____
   - ☐ Other: _____

4. Check all that describes how you feel, or what happens to you, after a seizure:
   - ☐ I feel embarrassed
   - ☐ I feel drowsy or sleepy
   - ☐ I feel nauseated
   - ☐ I fall into a deep sleep
   - ☐ I feel angry
   - ☐ I am confused
   - ☐ My walk becomes unsteady
   - ☐ I have a loss of memory
   - ☐ I feel fine and just pick up where I left off when it is over
   - ☐ I get a headache (check one: ☐ severe; ☐ bad; ☐ medium; ☐ light)
   - ☐ I want to be alone after a seizure (for ☐ several minutes; ☐ several hours)
   - ☐ Other: _____

5. How long does it take you to recover from a seizure? _____

6. When do your seizures usually occur?
   - ☐ Only in the early morning
   - ☐ Only in the early evening
   - ☐ Only when I am sleeping
   - ☐ At any time of day or night
   - ☐ Other: _____

7. How do your seizures occur? ☐ Singly ☐ In groups ☐ In clusters

8. How old were you when you first started having seizures? _____

9. How old were you when you were diagnosed with having seizures? _____

10. How severe or strong are your seizures?
    - ☐ Not severe or strong (weak)
    - ☐ Moderate or mild
    - ☐ Very severe, or strong

11. How do seizures affect your normal daily activities?
    - ☐ Not at all
    - ☐ A little, or moderately
    - ☐ A lot, or significantly

Medications

1. If you take any medication(s), please indicate the amount (in milligrams-mgs) that you now take and describe any side effects that you experience.

Code	Trade Name	Generic Name	Amount	Side Effects You Experience
1	Celontin	Methsuximide		
2	Depakene	Valproic Acid		
3	Depakote	Valproic Acid - Coated		
4	Diamox	Acetazolamide		
5	Dilantin	Phenytoin		
6	Felbatol	Felbamate		
7	Gabatril	Tiagabine		
8	Keppra	Levetiracetam		
9	Klonopin	Clonazepam		
10	Lamictal	Lamotrogine		
11	Luminal	Phenobarbital		
12	Mysoline	Primidone		
13	Neurontin	Gabapentin		
14	Ritalin	Methylphenidate		
15	Tegretol	Carbamazepine		
16	Topamax	Topiramate		
17	Trileptal	Okarbazepine		
18	Valium	Diazepam		
19	Zarontin	Ethosuximide		
20	Zonegran	Zonisamide		
21	Other _____			
22	Other _____			
23	Other _____			

2. Do you take your medication(s) as instructed?

___ Always ___ Usually ___ Sometimes ___ Never

3. Please check side effects which you experience from you medication(s):

_____ Poor coordination _____ Slow movement _____ Drowsiness

_____ Slow thinking _____ Double vision _____ Blurred vision

_____ Dry skin / skin rash _____ Excessive sweating _____ Dry mouth / thirst

_____ Gum problems _____ Weight gain _____ Increased heart rate

_____ Diarrhea _____ Irritability