macro-pro

646806-19
(Paper-A-68) (1)

CLAIM #/FILE #: 2080381794

DELIVER TO:
NATALIA FOLEY, ESQ.
WORKERS' DEFENDERS LAW GROUP
8018 E. SANTA ANA CANYON ROAD #100-215
ANAHEIM, CA 92808

INVOICE #: 3524854 **ONLINE ORDER #:** 335198

RECORDS OF: ANISA CHANEY

CASE NAME: ANISA CHANEY vs. BOLD QUAIL HOLDINGS, LLC

CASE #: ADJ13521045; ADJ13521436 **INJURY DATE:** 1/6/20-6/30/20; ET AL.

RECORD LOCATION: STARS BEHAVIORAL HEALTH GROUP
1501 HUGHES WAY # 150
LONG BEACH, CA 90810

REQUESTED: MEDICAL, BILLING, PSYCH, FILM RPTS, OTHER (SEE SUBPOENA)

PLEASE NOTE: PLEASE REFER TO THE AFFIDAVIT

ORDERED BY: AMANDA A. MANUKIAN, ESQ.
FLOYD SKEREN PASADENA
WESTLAKE VILLAGE

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P.O. Box 93010, Long Beach, California 90809-3010
Phone: 1(800) 696-2511 Fax: 1(888) 696-2270

August 26, 2021

STARS BEHAVIORAL HEALTH GROUP
1501 HUGHES WAY, # 150
LONG BEACH, CA 90810

Dear Custodian of Records,

This is a request to your facility to release records pertaining to the attached authorization. The following information has been supplied to help identify the correct file.

Name: ANISA CHANEY
DOB: 09/06/1973
SSN: XXX-XX-6450

Special Instructions: ALL DOCUMENTS IN YOUR POSSESSION OR CONTROL WHICH INCLUDES, BUT IS NOT LIMITED TO, ALL PSYCHIATRIC RECORDS, REPORTS OF X-RAYS, REPORTS OF FILMS, DIAGNOSTIC REPORTS, TESTING AND RESULTS, RADIOLOGICAL READINGS, MEDICAL REPORTS, MEDICAL RECORDS, REPORTS OF OTHER PHYSICIANS, MEDICAL REFERRALS, PHYSICIAN LETTERS AND RECOMMENDATIONS, RFAS, CHARTS, NOTES, INTAKE FORMS, MEDICAL QUESTIONNAIRES, UTILIZATION REVIEW DETERMINATIONS, IMR DETERMINATIONS, BILLING AND LIENS, PERTAINING TO ANISA CHANEY (SSN: XXX-XX-6450; DOB: 09/06/1973). TO INCLUDE ALL INFORMATION CONSISTENT WITH ANY LIMITATIONS OF THE ATTACHED AUTHORIZATION, WHETHER THAT INFORMATION IS FROM ANY PRIVATE TREATMENT, LIABILITY TREATMENT OR WORKERS' COMPENSATION TREATMENT FILE. SEE ATTACHED AUTHORIZATION.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA) PROHIBITS EMPLOYERS AND OTHER ENTITIES COVERED BY GINA TITLE II FROM REQUESTING OR REQUIRING GENETIC INFORMATION OF AN INDIVIDUAL OR FAMILY MEMBER OF THE INDIVIDUAL, EXCEPT AS SPECIFICALLY ALLOWED BY THIS LAW. TO COMPLY WITH THIS LAW, WE ARE ASKING THAT YOU NOT PROVIDE ANY GENETIC INFORMATION WHEN RESPONDING TO THIS REQUEST FOR MEDICAL INFORMATION. "GENETIC INFORMATION" AS DEFINED BY GINA, INCLUDES AN INDIVIDUAL'S FAMILY MEDICAL HISTORY, THE RESULTS OF AN INDIVIDUAL'S OR FAMILY MEMBER'S GENETIC TESTS, THE FACT THAT AN INDIVIDUAL OR AN INDIVIDUAL'S FAMILY MEMBER SOUGHT OR RECEIVED GENETIC SERVICES, AND GENETIC INFORMATION OF A FETUS CARRIED BY AN INDIVIDUAL OR AN INDIVIDUAL'S FAMILY MEMBER OR AN EMBRYO LAWFULLY HELD BY AN INDIVIDUAL OR FAMILY MEMBER RECEIVING ASSISTIVE REPRODUCTIVE SERVICES.

Please **call us** as soon as the records are available or **refer to the attached Notice to Custodian** for additional options. Remember that section 1158 of the California Evidence Code requires that the records be made available within 5 days of receipt of this Authorization.

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P.O. Box 93010, Long Beach, California 90809-3010
Phone: 1(800) 696-2511 Fax: 1(888) 696-2270

If you have any questions, please call us at (888) 898-3430 or (562) 595-0900 and refer to Macro-Pro Job # 646806-19.

Date: _____

Served To: _____

Address: 1501 HUGHES WAY # 150
LONG BEACH, CA 90810

Served By: _____

Sincerely,
MACRO-PRO, INC.

EVIDENCE CODE SECTION 1158

... no copying may be performed by any medical provider or by an agent thereof, when the requesting attorney has employed a professional photocopier ...

... failure to make records available, during business hours, within five days after the presentation of the written authorization, may subject the person or entity having custody or control of the records to liability for all reasonable expenses, including attorney's fees, incurred in any proceeding to enforce the provisions of this section ...

... where the records are produced for inspection or photocopying at the record custodian's place of business, the only fee for complying with the authorization shall not exceed fifteen dollars ($15) ...

JOB #: 646806-19

PROOF OF SERVICE

ANISA CHANEY vs. BOLD QUAIL HOLDINGS, LLC

Case No: ADJ13521045; ADJ13521436

I am over the age of eighteen years and not a party to the within action; my business address is P.O. Box 93010, Long Beach, CA 90809; I am employed in Los Angeles County, California.

The Authorization (to include Notice and Declarations as required by law) was served on the person/persons listed below, addressed as follows:

STARS BEHAVIORAL HEALTH GROUP
1501 HUGHES WAY # 150
LONG BEACH, CA 90810
Attention: MEDICAL RECORDS

☒	**BY MAIL:** I enclosed the documents in a sealed envelope or package addressed to the persons at the addresses as listed above. The documents would be placed in an envelope for collection and mailing, following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid. I am a resident or employed in the county where the mailing occurred. The envelope or package was placed in the mail at Long Beach, California.
☐	**BY OVERNIGHT DELIVERY:** I enclosed the documents in an envelope or package provided by an overnight delivery carrier and addressed to the persons at the addresses listed above. I placed the envelope or package for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
☐	**BY FAX:** Based on an agreement of the parties to accept service by fax transmission, I faxed the documents to the persons at the fax number: . No error was reported by the fax machine that I used. A copy of the record of the fax transmission, which I printed out, is attached. The fax number from which I served the documents is: (888)696-2270.
☐	**BY ELECTRONIC TRANSMISSION:** I caused the above-referenced documents to be transmitted via email from: everlyn@macropro.com to .

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on August 26, 2021, in Long Beach, California.

EVERLYN DIONICIO
(TYPE OR PRINT NAME OF DECLARANT)

(SIGNATURE OF DECLARANT)

0468006-19

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HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize: Stars Behavioral Health Group
Name of Facility with Records/Disclosing Party

2.) To disclose to: Floyd Skeren et al
Name of Requesting Party (Requester): Insurance Carrier/Third Party Administrator/Self-Insured Employer/Attorney Firm

and/or their attorneys, through **Macro-Pro their agent**, to review, inspect, and/or photocopy **any and all of the following from any and all dates** which are in your possession or control:

Anisa Chaney (Name of Patient (List Other Names Used)) 09 / 06 / 1973 (Date of Birth) 6450 (Last 4 of SSN)

- **Medical records**, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, diagnostic images, billings and laboratory reports.
- **Employment and/or Union records** to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records. • **Scholastic Records**
- **EDD Disability and Unemployment Records**
- **Insurance and Claim Records**
- **Police, Prison or Probation Records**
- **Pharmacy Records**

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

AC (Initial) **Psychiatric and Mental Health Information**

____ (Initial) **HIV and/or AIDS Information**

____ (Initial) **Alcohol and/or Drug Information**

____ (Initial) **Genetic Records**

____ (Initial) **Sexually Transmitted Disease Information**

Date Range of Records to be Released 09 / 06 / 1973 to 06/02/2021

The health information authorized on this form will be used for the following purposes only: **Discovery for a Liability or Workers' Compensation claim.**

DURATION: This authorization shall become effective immediately and shall remain in effect until_____or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. **Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.**

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization.
A copy of this authorization shall be considered as valid as the original.

Anisa Chaney (Signature) | Anisa Chaney (Print Name) | 06-16-21 (Date)

If Signed by Other than Patient, Indicate Relationship

AUTHORIZATION 2021 HIPAA

macro-pro

P.O. Box 93010, Long Beach, California 90809-3010
Phone: 1(800) 696-2511 Fax: 1(888) 696-2270

QUALITY CONTROL

Date: _____

RE: ANISA CHANEY
DOB: 09/06/1973 SSN: XXX-XX-6450
File #:
Claim #: 2080381794

Job #: 646806-19

Records have been verified as pertaining to those requested on the basis of:

- [X] Name
- [X] Date of Birth
- [ ] File or Claim #
- [ ] Other _____
- [ ] AKA
- [X] Social Security #
- [ ] No Verifiable Data

As you requested, these records consist of:

- [ ] Any and All Records Available
- [ ] Only those Records consistent with Specified Omissions:

_____

_____

Quality Certified By:

_____ / ___ / ____		BM 9/24/21	
Field Representative	Date	Billing Department	Date
_____ / ___ / ____		_____ / ___ / ____	
Tabbing Department	Date	Production Department	Date

If you receive any page that you cannot read or have any questions regarding these records or your order, please call Macro-Pro Client Services or any Macro-Pro Manager at (888) 554-0900

CUSTODIAN AFFIDAVIT

JOB #: 646806-19
Page 1 of 1

Custodian of Records for STARS BEHAVIORAL HEALTH GROUP,

Records of: ANISA CHANEY
DOB: 09/06/1973 SSN: XXX-XX-6450

I, the undersigned, being the duly authorized **Custodian of Records** or other qualified witness with the authority to certify the records and I hereby declare:

All records or items provided are a TRUE COPY of the records requested in the SUBPOENA, AUTHORIZATIONS, or NOTICE, and they were prepared by the personnel of the business in the ordinary course of the business at or near the time of the act, condition or event.

All records or items not provided either do not exist or cannot be found with the information provided.

PLEASE COMPLETE THIS SECTION AND SIGN

RECORDS OR ITEMS	PROVIDED? YES	PROVIDED? NO	LOST	DESTROYED	OTHER
Medical Records	✓				
Psychiatric Records	✓				
Film Records		✓			
Medical Billing		✓			
Others		✓			
ELECTRONIC RECORDS	✓				

( ) I am not the custodian of these records. The records may be held by the following facility/custodian.

New Facility/Custodian _____ Phone _____

I declare under penalty of perjury under the laws of this state that the foregoing is true and correct.

X Caroline Viramontes
Signature of the Custodian or Qualified Witness

Carolina Viramontes
Print Name

9/22/2021
Date

(562) 548-6565
Phone Number

You may satisfy the requirements of the Subpoena, Authorization or Notice by eMail, fax, mail or allowing Macro-Pro to copy or pickup records.

eMail: sendrecords@macropro.com (or) Fax: (888) 696-2270 (or) Mail to P.O. Box below
Call us for assistance Phone: (888) 898-3430

AFFIDAVIT OF THE PROFESSIONAL PHOTOCOPIER: (MACRO-PRO USE ONLY)

I declare under penalty of perjury that I am an employee/agent of Macro-Pro, Inc. and that I made true and complete copies of all records delivered to me.

Signature of Professional Photocopier _____ Date _____ Rep Number _____

☐ Custodian did not sign this Affidavit ☐ Custodian provided the attached Affidavit

Stars Behavioral Health Group
BHUCC Aftercare Instructions 19.12

Patient Name	*Date of Birth*	*Gender*	*ID No.*
Chaney, Anisa	09/06/1973	F	00072499

General Information

Client	*Event*	*Date completed [PST]*	*Completed by*
Chaney, Anisa	BHUCC Aftercare Instructions 19.12	5/14/2020 8:50 PM	Waldbillig, Sean

Allergies

Known Allergies

Type	Allergy	Allergy Details
Medications	O	

Medications

Current Medications

Medication	Rationale	Started	Date Discontinued	Frequency	Route	Duration	Dose	Strength	Take/sig	Prescribed by	Remarks
Ativan 0.5 MG Oral Tablet		5/14/2020 12:00 AM	5/23/2020 12:00 AM		Oral	10 days		0.5 MG	Take one (1) tablet by mouth twice a day, as needed	Achuamang, Irine	
Vistaril 25 MG Oral Capsule		5/14/2020 12:00 AM	6/12/2020 12:00 AM		Oral	30 days		25 MG	Take one (1) capsule by mouth twice a day, as needed	Achuamang, Irine	

Aftercare Instructions

Type: *Tipo*

○ Transfer *Transferir* ◉ Discharge *Dar de Alta*

Discharge or Transfer Date and Time: *Tiempo y Fecha de Dar de Alta o Transferir:*

5/14/2020

Provisional Discharge Diagnosis or Transfer Diagnosis: ***Diagnostico provisional al tiempo de descarga o transferir:***

Diagnosis per NP: Generalized Anxiety Disorder

Medications Prescribed: ***Medicamentos Prescritos:***

Prescribed: Ativan 0.5 MG twice daily as needed for ten days and Vistaril 25 MG twice daily as needed for 30 days
Pick up from CVS 3880 W. Rosecrans
Hawthorne, CA

Dietary Requirements: ***Requisitos Dieteticos:***

Maintain Healthy Diet as possible

Rehabilitation Potential: ***Potencial de Rehabilitacion:***

Fair to Good with continued therapy, medication and consideration of leave from work.

Known Behaviors or Symptoms of Mental Disorder: ***Comportamientos conocidos/Sintomas de Diagnostico Mental:***

Behaviors consistent with diagnosis.

Follow-up Appointments and Referrals: (Mental Health and Medical) ***Citas de Seguimiento y Referencias: (Medical y Salud Mental)***

Follow up with private therapy options provided:
Most locations have multiple therapists
Look into EMDR, but focus on anxiety and stress management therapy as well as grief support.

Additional information provided for FMLA
Discuss taking health leave with PCP.

If in crisis return to BHUCC
3210 Long Beach Blvd.

Discharge or Transfer Destination: ***Dar de Alta/Destino de Transferencia:***

Back to Family Home

Who is providing transportation? (if applicable) ***Quien esta proporcionando transporte?***

Self

Legal Status at time of Discharge or Transfer: ***Estado legal al momento de descarga o transferir:***

N/A

Legal Guardian or Conservator's Name: ***Nombre de guardian legal/conservador:***

Acknowledgement

I understand and have received a copy of the above aftercare/transfer instructions, and emergency services guide.
Entiendo y he recibido una copia de las instrucciones de cuidado posterior/transferencia, y guia de los servicios de emergencia.

I understand that I may also designate another person to receive a copy of this aftercare/transfer plan on my behalf. I hereby request and consent to have a copy of this plan released to the person designated below.
Entiendo que tambien puedo designar a otra persona para recibir una copia de las instrucciones de cuidado en mi nombre.

If a designee is identified, identify the designee's relationship to the client and the designee's contact details (address and phone number).
Si es aplicable, identifica el nombre y relacion de la persona designada con direccion de casa y numero de telefono.

Designated Person (If applicable)

Emergency Services Guide

After-Hours Emergency Phone / *Linea de emergencia despues de horas de oficina*: (562) 548-6565

Local Hospital / *Hospital Local* (24 hours): Long Beach Memorial Medical Center (562) 933-2000, 2801 Atlantic Ave. Long Beach, CA 90806

Police / Fire / Ambulance (24 hours): 911 or local police (562) 435-6711

Poison Control / *Control de veneno* (24 hours): (800) 876-4766

Emergency Psychiatric Assessments / *Evaluacion psiquiatrica de emergencia* (24 hours): Del Amo Hospital (800) 533-5266 College Hospital (855) 844-8898

Suicide Prevention Hotline/ *Linea para impedir suicidio* (24 hours): (310) 391-1253 or (800) 273-8255

Trevor Project Hotline LGBTQ / *Linea al Projecto Trevor* (24 hours): (866) 488-7386

Crisis Text Line / *Linea de crisis via texto* (24 hours): Text "HOME" to 74174 (standard messaging rates apply)

Child Abuse Hotline / *Linea directa de abuso infantil* (24 hours): Dept. of Childrent & Family Services (800) 540-4000
Missing Children Hotline / *Linea directa de ninos perdidos* (24 hours): (800) 222-3463

Patients' Rights Bureau / *Oficina de los derechos de pacientes* (24 hours): (800) 700-9996

L.A. County DMH PMRT Crisis / *Departamento de salud mental del condado de Los Angeles linea de emergencia* (24 hours): (800) 854-7771

I acknowledge that I have received a copy of this document in addition to the Los Angeles County Department of Mental Health Grievance and Appeal Procedures - a Consumer's Guide and A Guide to Medi-Cal Mental Health Services, and that further copies are available m the lobby.

He recibido una copia de este documento y del folleto del condado de Los Angeles - Departamento de Salud Mental sobre procedimientos para quejas y apelaciones - guia para el consumidor, y el Guia Para Servicios de Salud Mental de. Medi-Cal y que copias adicionales son disponible en la oficina en la area de recepcion.

Additional Information

Client/Guardian was provided with a copy?

Y - Yes

Remarks

Confidentiality Statement

Service Related Encounter Information

Exempt from Billing	*Activity Type*	*Client Involved*	*Program Providing Service*
No		Yes	BHUCC - BHUCC (00543)

Facility Providing Service	*Encounter With*	*Service Authorization*
00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)		

Signatures

Date	Name	Action	Signature
5/14/2020 8:58 PM	Waldbillig, Sean (ASW) Mental Health Specialist II	Submit Event	ASW 83301, MHS II
5/15/2020 9:16 AM	Jenks, Connelly (LCSW) Clinical Supervisor	Approve Event	LCSW 69018, Clinical Supervisor

Stars Behavioral Health Group
SBHG Life Events Checklist 19.06

Patient Name	Date of Birth	Gender	ID No.
Chaney, Anisa	09/06/1973	F	00072499

Encounter Information

Client	Event	Actual Date [PST]	Service Site
Chaney, Anisa	SBHG Life Events Checklist 19.06	5/14/2020 7:50 PM	20 - Urgent Care

Staff	Submit to	Entered With
Waldbillig, Sean	Jenks, Connelly (Clinical Supervisor)	Agency Placement - 05/14/2020 04:00pm

Checklist

(Adapted from the LEC-5)

Listed below are a number of difficult or stressful things that sometimes happen to people.

For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Event

1. Natural disaster (for example, flood, hurricane, tornado, earthquake)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

2. Fire or explosion

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

4. Serious accident at work, home, or during recreational activity

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

5. Exposure to toxic substance (for example, dangerous chemicals, radiation)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

9. Other unwanted or uncomfortable sexual experience

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

10. Combat or exposure to a war-zone (in the military or as a civilian)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

12. Life-threatening illness or injury

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

13. Severe human suffering

☑ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☐ (f) Doesn't Apply

14. Sudden violent death (for example, homicide, suicide)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☑ (e) Not Sure

☐ (f) Doesn't Apply

15. Sudden accidental death

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☑ (e) Not Sure

☐ (f) Doesn't Apply

16. Serious injury, harm, or death you caused to someone else

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

17. Neglect (e.g. physical, emotional, medical)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

18. Exploitation (for example, being taken advantage of for someone else's benefit financially, sexually, etc.)

☐ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☑ (f) Doesn't Apply

19. Any other very stressful event or experience

☑ (a) Happened to me ☐ (b) Witnessed it ☐ (c) Learned about it ☐ (d) Part of my job ☐ (e) Not Sure

☐ (f) Doesn't Apply

Additional Information

Remarks (If none add None or N/A below):

Clt reported trauma mostly not classifiable on the LEC. Clt reported he Mother died suddenly when she was 19 years old and her Father died 3 years later. Clt reported being the primary caretaker for her Grandmother for multiple years through her Grandmother's Alzheimer's and up until death. Clt reported taking care of her daughter now age 26 through onset of psychosis. Clt also reported period of homelessness, and her husband leaving her 3 years ago due to stress of caretaking for her daughter with psychosis.

Confidentiality Statement

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable W and I Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without written authorization of client/authorized representative to who it pertains unless otherwise permitted by law.

Service Related Encounter Information

Exempt from Billing	*Activity Type*	*Client Involved*	*Program Providing Service*
No		Yes	BHUCC - BHUCC (00543)

Facility Providing Service	*Encounter With*	*Service Authorization*
00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)		

Signatures

5/19/2020 4:07 PM	Waldbillig, Sean (ASW) Mental Health Specialist II	Submit Event	[signature], ASW63301, MHS II
Date	Name	Action	Signature
5/19/2020 4:07 PM	(ASW)	Approve Event	[signature], ASW63301, MHS II
Date	Name	Action	Signature

Stars Behavioral Health Group
BHUCC Client Resource Evaluation 18.06

Patient Name	Date of Birth	Gender	ID No.
Chaney, Anisa	09/06/1973	F	00072499

GENERAL INFORMATION

Client	Event	Date [PST]	Completed By
Chaney, Anisa	BHUCC Client Resource Evaluation	5/14/2020 7:45 PM	Waldbillig, Sean

Submit To

Jenks, Connelly (Clinical Supervisor)

PERSONAL INFORMATION

Gender	SS#	DOB	Age	Ethnicity	Ethnicity Details	Religion	Eye Color	Hair Color	Citizenship	Veteran	Language	Ethnicity Details Standard Code	Special Accomodations Needed
Female	561-39-6450	9/6/1973	48	Unknown / Not Reported						No	English		No

Race	Other
Black or African American	

ASSESSMENT

Client Resouce Evaluation

INCOME

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported having income from work as an RN.

FOOD

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported having enough food.

HOUSING

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported having stable housing with her two children ages 26 and 14.

MEDICAL CARE

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported having medical care as needed through Aetna private insurance.

WORK/VOLUNTEER WORK/PREPARATION FOR WORK

Resource Needs:

☐ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported having work as a RN. Clt reported looking for resources for leave from work due to covid-19 related stressors.
Clt will be provided with FMLA related resources.

CHILDCARE

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported no need for childcare.

TRANSPORTATION

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported having a car for transportation as needed.

LEGAL ADVICE

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need at recommendation / plan:

Clt reported no legal problems.

IMMIGRATION ASSISTANCE

Resource Needs:

☑ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt reported no immigration problems.

OTHER

Other Needs

Mental Health/Overall.

Resource Needs:

☐ No Need ☐ Client declines help at this time

Describe need and recommendation / plan:

Clt provided with private therapy options through Aetna near Hawthorne. Multiple clinics provided.
Clt provided with information for FMLA leave due to work stressors related to Covid.
Clt provided with therapy resources (window of tolerance, grounding, and information on EMDR therapy).

SIGNATURES

Client Signature

Not on file.

Additional Information

Remarks

Confidentiality Statement

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Service Related Encounter Information

Exempt from Billing	*Activity Type*	*Client Involved*	*Program Providing Service*
No		Yes	BHUCC - BHUCC (00543)

Facility Providing Service	*Encounter With*	*Service Authorization*
00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)		

Signatures

Date	Name	Action	Signature
5/19/2020 3:56 PM	Waldbillig, Sean (ASW) Mental Health Specialist II	Submit Event	[signature], ASW63301, MHS II
5/19/2020 4:12 PM	Jenks, Connelly (LCSW) Clinical Supervisor	Approve Event	[signature] LCSW69018, Clinical Supervisor

Stars Behavioral Health Group
BHUCC Progress Note

Patient Name	Date of Birth	Gender	ID No.
Chaney, Anisa	09/06/1973	F	00072499

Encounter Information

Client Name
Chaney, Anisa

Type
BHUCC Progress Note - Mental Health Specialists

Completed Information

Actual Date/Time [PST]
5/14/2020 7:30 PM

Completed By
Waldbillig, Sean

Additional Information

Remarks

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Service Related Encounter Information

Program Providing Service
BHUCC - BHUCC (00543)

Facility Providing Service
00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)

Service Authorization

Progress Note

Progress Note

Behavior:

Clt presented at CWIC seeking medication support and therapeutic support due to added stressors related to covid-19 pandemic and work as an RN. Clt reported anxiety symptoms specifically increase in worry which is difficult to control, overthinking, fear of contracting Covid-19/spreading Covid to family members, and feeling on edge. Clt meets medical necessity due to difficulties maintaining work and daily functioning due to anxiety.

Intervention:

MHS II introduced himself and limits of confidentiality. MHS II consented clt and redirected clt as needed to discuss screenings in connection to resources needed and trauma/stressors faced. MHS II validated and praised clt's openness to therapy in addition to medication at BHUCC. MHS II assessed clt through CSSR and BPRS as needed. MHS II provided space for clt to detail her stressors and how they are impacted by pandemic. MHS II provided space for clt to discuss previous traumatic incidents/loss and its relationship to her current loss/stressors. MHS II provided with psycho-education on connection between past trauma, current stressors and anxiety symptoms. MHS II encouraged clt to discuss ways she has coped with anxiety/stress previously and what she utilizes currently. MHS II provided space for problem solving and reality testing about clt's ability to continue work during pandemic and noted resources could provide for clt to deal with difficult situation. MHS II asked some questions from WRAP to help orient clt.

Response:

Clt reported increasing stressors due to working as an RN at a SNF during pandemic. Clt reported not working on covid unit but still being at risk. Clt noted few precautions being taken with minor use of PPE and many of her clients dying. Clt noted 20 plus clients dying in the last few months related to Covid who she had worked with over 10 years. Clt noted having increased difficulties supervising her team as an RN. Clt noted not trusting organization and worries about spreading covid between patients or to family. Clt noted uncertainty about her ability to continue working.

Clt reported past trauma and loss which was being brought up by pandemic. Clt's trauma mostly not classifiable on the LEC. Clt reported her Mother died suddenly when she was 19 years old and her Father died 3 years later. Clt reported being the primary caretaker for her Grandmother for multiple years through her Grandmother's Alzheimer's and up until death. Clt reported taking care of her daughter now age 26 through onset of psychosis. Clt also reported period of homelessness, and her husband leaving her 3 years ago due to stress of caretaking for her daughter with psychosis. Clt noted also taking care of her younger sister from age 5 onward due to her parents dying.

Clt was open to discussing some coping mechanisms. Clt noted reaching out for medical support and getting two Covid tests recently. Clt reported both tests were negative. Clt noted knowing her tests were negative making her feel somewhat better. Clt reported actively praying (specifically the Serenity prayer) and utilizing her religion for support. Clt noted smoking meaning she takes breaks and gets a deep breath. Clt was open to discussing needing to exhale and let go of tension when possible. Clt noted support from her children and now adult sister. Clt noted also really enjoying nursing and hope that that joy would return. Clt receptive to therapy at BHUCC and noted wanting community therapy.

Plan:

Clt will be discharged with medication and follow up for psychiatry/therapy through her private insurance near Hawthorne. Clt provided with information for FMLA leave due to work stressors related to Covid. Clt provided with therapy resources (window of tolerance, grounding, and information on EMDR therapy).

Signatures

5/19/2020 5:24 PM	Waldbillig, Sean (ASW) Mental Health Specialist II	Submit Event	[signature], ASW#63301, MHS II
Date	Name	Action	Signature
5/20/2020 9:48 AM	Jenks, Connelly (LCSW) Clinical Supervisor	Approve Event	[signature] LCSW#90183, Clinical Supervisor
Date	Name	Action	Signature

Stars Behavioral Health Group
BHUCC Practitioner Assessment 19.04

Patient Name	Date of Birth	Gender	ID No.
Chaney, Anisa	09/06/1973	F	00072499

ENCOUNTER INFORMATION

County ID	Client	Event	Activity Type
7162172	Chaney, Anisa	BHUCC Practitioner Assessment 19.05	Telepsychiatry-IBHIS

Actual Date [PST]	Completed By	Submit To
5/14/2020 6:40 PM	Achuamang, Irine	Achuamang, Irine (Psychiatric Nurse Practitioner)

DEMOGRAPHICS

Gender	SS#	DOB	Age	Ethnicity	Ethnicity Details	Religion	Eye Color	Hair Color	Citizenship	Veteran	Language	Ethnicity Details Standard Code	Special Accomodations Needed
Female	561-39-6450	9/6/1973	48	Unknown / Not Reported						No	English		No

Race	Other
Black or African American	

ASSESSMENT

PRESENTING PROBLEM; CHIEF COMPLAINT

(Current Symptoms, Behaviors and Impairments in Life Functioning)

☐ Suicide Attempt ☐ Suicide Ideation ☑ Seeking Therapeutic Services ☐ Medication Refill

☐ Danger to Self ☐ Danger to Others ☐ Gravely Disabled ☐ Seeking Resources

DIAGNOSIS INFO

Add Diagnosis

Type	Diagnosis Type	Diagnosis	Diagnosis Priority	Program Providing Diagnosis
Diagnosis General	1 - Admission	GAD (generalised anxiety disorder); ICD9: 300.02; ICD10: F41.1; SNOMED: 21897009; DSM4 Term: Generalized anxiety disorder; DSM5 Term: Generalized anxiety disorder;	1 - 1 - Primary	BHUCC - BHUCC (00543)
Diagnosis General	1 - Admission	MDD (major depressive disorder), recurrent episode; ICD9: 296.30; ICD10: F33.9; SNOMED: 268621008; DSM4 Term: Recurrent major depressive; DSM5 Term: Major depressive disorder, recurrent episode, unspecified; Cat: Mood Disorders/ Depressive Disorders	2 - 2 - Secondary	BHUCC - BHUCC (00543)

Confidentiality Statement

Remarks

Confidentiality Statement

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Tasks/Schedules

Schedule Next

Next Scheduled Event

Event

Last Name	First Name	Event	Due Date/Time	Scheduled Date/Time	Staff

No information on file

Service Related Encounter Information

Exempt from Billing

No

Client Involved

Yes

Program Providing Service

BHUCC - BHUCC (00543)

Facility Providing Service

00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)

Encounter With

Service Authorization

Progress Note

Progress Note

REFERRAL SOURCE: Walk-in<"xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

CHIEF COMPLAINT "I am not well"

HISTORY OF PRESENTING ILLNESS (chart reviewed, available collateral info reviewed, staff data reviewed, and patient interviewed). Client is a 46 yo male who walked into the CWIC for an assessment. Client reports increase anxiety, intense feeling of being overwhelmed, recurrent shaking hands and panicky feeling, SOB and increase HR. States anxiety attacks occurs multiple times a day and makes it hard for her to complete daily activities and particularly her job. Client reports intense discomfort and inability to have a relaxed mind at work which usually triggers a need to run away from the situation. Client reports poor sleep on some days and excessive sleep on other days. Client reports very poor appetite. Client reports intense sadness and an urge to cry several times a week. Client states she has been experiencing anxiety and occasional sadness for several years, however she has always been able to regulate herself. States symptoms have gotten worst over the last month and she is unable to bring her thoughts and emotions under control as she did in the past. Client denies SI/HI/AH/VH/PI.

-Expresses no further questions or concerns at this time.

PSYCHIATRIC HISTORY:

-Diagnoses: Anxiety

-Psychiatric Hospitalizations: none

-Self-Injurious Behaviors/ suicidal attempts: none

-ACCESS to weapons (guns): none

-Outpatient Care: none

-Past Psychiatric Medications: Ativan 2 yrs ago (helpful), Gabapentin (helpful),

SUBSTANCE USE HISTORY:

-Alcohol: only on occasions about once a month.

-Illicit drugs: none

-Caffeine: none

-UDS : n/a

BIRTH AND DEVELOPMENTAL EVENTS OF SIGNIFICANCE: none

CURRENT PRIMARY CARE PROVIDER: DR. Hernandez Valentine

FAMILY HISTORY: Mother-depression(deceased), Daughter-Bipolar/Schziphrenia Father-alcoholic (deceased), Brother-Bipolar

PSYCHOSOCIAL HISTORY:

-Past Trauma: none

Education: BS

Employment history: employed fulltime

Legal:none

Living arrangement/Relationships: lives with her 26 yo daughter and 14 yo son. Seperated from spouse x 3 years.

Protective Services:

PAST MEDICAL HISTORY:

-Medical issues: none

-Past surgeries: none

ACTIVE MEDICATIONS:

Psychiatric: none

Medical: none

Drug allergies: NKDA

CLIENT'S STRENGTH:

-Absence of SI/HI.

-Future oriented thoughts.

-Good Support system.

-Supportive family

-Seeking help.

-Willingness to engage in treatment.

-Good physical health.

-Access to care.

RISK FACTORS:

-Stressful job situation

MENTAL STATUS EXAMINATION:

Appearance: Appears stated age, casual dress, fair grooming and hygiene, seated appropriately.

Attitude / Behavior: Calm and cooperative. Culturally, appropriate eye contact.

Psychomotor: No clear psychomotor retardation, agitation, or tremor

Speech: Spontaneous, fluent, and of appropriate volume and prosody

Mood: "anxious"

Affect: worried, tearful.

Intellectual functioning: good

Fund of Knowledge: good

Concentration:fair

Abstraction: good

Memory: intact.

Thought Process: Coherent, logical, linear

Thought Content: Denies suicidal ideation, homicidal ideation, no delusions of grandeur or paranoia elicited

Perceptual Disturbances: Denies auditory hallucinations, visual hallucinations, ideas of reference, thought broadcasting, and thought insertion

Cognition: grossly intact (although not formally tested today); alert and oriented x 4

Insight/Judgement: fait

DSM-V DIAGNOSTIC IMPRESSION Mental Health Diagnoses and Relevant Medical Conditions:

-GAD

-MDD recurrent mild

ASSESSMENT:

Client is a 46 yo female presenting for an assessment. Clinical presentation meets criteria for GAD and MDD. Client denies any ongoing mental health services and expresses interest in medication management and therapy. Client is receptive to teachings and treatment recommendations. After thorough psychiatric assessment including unique risk and protective factors, and observation, patient is determined to be at LOW acute risk of suicide and violence at the time of discharge. While future psychiatric events cannot accurately be predicted, the patient does not currently require further admit to inpatient psychiatric care. We have attempted to mitigate patient's risks through supportive brief psychotherapy, psychoeducation for the patient, thoughtful medication management, and ensuring outpatient follow-up. Additional protective factors include:

-lack of current SI

-no access to weapons

-supportive family

-access housing

-future-oriented thinking

-access to care

-willingness to engage in treatment

PLAN:

-Client's participation : agrees to participate in treatment. Client agrees to PRN medications only for anxiety

-Psychiatric: referral for ongoing services.

-Psych meds: Vistaril 25 mg bid prn , Ativan 0.5 mg bib prn

-R/B/SE/A discussed with patient who signed medication consent (please see scanned document)

-Advised patient to avoid nicotine, alcohol, and illicit drugs while on medication

-Emergency resources reviewed including 911, suicide hotline, and local emergency rooms

-Provided a handout summarizing plan

Medical:

-no acute issues identified at this time

-continue routine f/u with PMD

-maintain heart healthy diet and daily activity as tolerated.

-minimize or avoid caffeine since can worsen (stress, sleep quality, anxiety in some cases).

Legal:

-patient does not meet LPS hold criteria

Follow Up:

-return to BHUCC as needed.

-explained walk-in nature of clinic and hours of operation.

-Follow up with outpatient clinic as directed.

Signatures

Date	Name	Action	Signature
5/15/2020 10:26 AM	Achuamang, Irine (NP) Psychiatric Nurse Practitioner	Submit Event	~~NP~~ 9507827.NP
5/20/2020 3:23 PM	Achuamang, Irine (NP) Psychiatric Nurse Practitioner	Approve Event	~~NP~~ 9507827.NP

Stars Behavioral Health Group
SBHG Claim Note 18.12

Patient Name	Date of Birth	Gender	ID No.
Chaney, Anisa	09/06/1973	F	00072499

No-Show Information

County ID	Exempt from Billing	No Show	Attempt to Contact
7162172	No	No	

Encounter Information

Client Name	Entered With	Type
Chaney, Anisa	Agency Placement - 05/14/2020 04:00pm	BHUCC Nursing Discharge Note 18.12

Completed Information

Admit Date/Time [PST]	Discharge Date/Time [PST]	Calculate	Duration (hh:mm)
5/14/2020 4:00 PM	5/14/2020 8:50 PM	Click Here	07:30

Total Time (hh:mm)	Evidence Based Practice/Service Strategy	Completed By	Submit To (RN on duty or Supervisor)
07:30	00 - 00 - No Evidence-Based Practice/Service Strategy	Arrajj, Michael	Arrajj, Michael (Registered Nurse (RN))

Service Site

20 - Urgent Care

Additional Information

Remarks

Service Related Encounter Information

Facility Providing Service

Program Providing Service

BHUCC - BHUCC (00543)

00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)

Service Authorization

Progress Note

Progress Note

Clt seen by MHS II and provider by Telecare. Was give DX of Generalized Anxiety D/O. To be started on Ativan 0.5mg Bib prn and vistaril 25 mg BID prn. given referrals for private therapy, Encouraged to consider a leave of absence from work (has had 20 people die at her work from CoVid), FMLA. Encouraged to consider EMDR Tx. Also told she could RTC as needed for f/u and support. D/C'ed with all her property to return home and in s/w less distress

Signatures

Date	Name	Action	Signature
5/14/2020 9:52 PM	Arrajj, Michael (RN) Registered Nurse (RN)	Submit Event	Michael Arrajj, 310359 RN
5/15/2020 10:10 PM	Arrajj, Michael (RN) Registered Nurse (RN)	Approve Event	Michael Arrajj, 310359 RN

Stars Behavioral Health Group
BHUCC Nursing Assessment CSSRS 19.12

Patient Name	Date of Birth	Gender	ID No.
Chaney, Anisa	09/06/1973	F	00072499

GENERAL INFORMATION

Client	Point Of Entry	Event	Actual Date [PST]
Chaney, Anisa	01 - Urgent (CWIC)	BHUCC Nursing Assessment with CSSRS 19.12	5/14/2020 4:00 PM

Interpreter Used	Informant	Patients rights reviewed / booklet given	Licensed Nurse
		Yes	Arrajj, Michael

Submit To
Arrajj, Michael (Registered Nurse (RN))

DEMOGRAPHICS

Gender	SS#	DOB	Age	Ethnicity	Ethnicity Details	Religion	Eye Color	Hair Color	Citizenship	Veteran	Language	Ethnicity Details Standard Code	Special Accomodations Needed
Female	561-39-6450	9/6/1973	48	Unknown / Not Reported						No	English		No

Race	Other
Black or African American	

ENROLLMENT INFORMATION

Program	Program Start Date	Criteria for Admission	Referral Source
BHUCC	5/14/2020 4:00 PM		Physican/ Psychiatrist/ Psychologist/ SW

LEGAL STATUS

Type	Legal Status	Effective Date
Legal Status	Vol - Voluntary Placement	5/14/2020

ALLERGIES

Add Allergies

Allergy	Date Identified	Status	Allergy Details/Other
9626 - O	5/14/2020	active - Active	

VITALS

Height in Inches	Weight (lb)	BMI Pct	BMI	Blood Pressure	Pulse	Temperature	Respiration
62	130		23.8	109/61	77	97.7	14

CLIENT REPORTED MEDICATIONS

Type	Remarks	Outcome
No information on file		

MEDICAL HISTORY

Type	Details
No information on file	

SUBSTANCE ABUSE INFORMATION

Chemical Use	Amount	Age of Fist Use	Frequency	Route	Date Last Used	Details
No information on file						

HOSPITALIZATION / PLACEMENT HISTORY

Type of Treatment	Reason	Hospital	Date From	Date To	Remarks
No information on file					

ASSESSMENT

Nursing Assessment

Criteria for Admission:

46 yo AA female self presents with c/os of stress and anxiety. states there have been a number of events and she is "trying to hold it together". Most recently - clt is a nurse, works at a SNF. Around two weeks ago was exposed to coronavirus. Had a test on May 5 that was neg. has no sx of Covid. About 6 years ago her daughter had a breakdown, was unstable for 5 years, but has been better for the last year. Also at that time there was severe marital stress. Clt did not elaborate. Has limited h/o psych Tx. Saw a psychiatrist in 2017. Not known if she was ever treated with medications. MSE: well nourished well devaloped female, cooperative with interview. No abnormal behavior or movements noted. Speech is soft, normal rhythm and rate, clear. Mood is depressed, affect tearful. T.P: coherent, linear, and goal-directed. Denies VH, AH, or delusions. T.C: denies SI, HI, or h/o same. Seems to be expending a large amount of psychic energy trying to stand up to her challenges. Insight and judgement good

PAIN ASSESSMENT

Are you experiencing any ongoing physical pain?

◉ If NO - No further Pain Assessment questions are required. ○ If YES - Identify the pain location

Location of Pain:

How would you rate the intensity of the pain on a scale from 1 to 10 with 10 being the worst pain you could imagine?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How long have you had this pain?

Are you currently being treated for this pain?

○ Yes ○ No

Is the treatment effective? (A pain rating of 4 or above indicates ineffective treatment)

○ Yes ○ No

If not being treated or treatment is not effective, a recommendation should be made for client to see a healthcare provider on site or referral to be made and document the recommendation.

PATIENT ORIENTATION:

☑ Oriented to Nursing Staff ☐ Oriented to Room ☐ Oriented to Meal times ☐ Oriented to Smoking Rules

☐ Oriented to Daily Routine ☑ Oriented to Telephone ☑ Oriented to Day Room

☑ Oriented to Services Available

Date of last Health and Physical Exam:

5/14/2020

MEDICAL CONDITIONS

Last PE 10/18. denies medical consitions

PSYCHIATRIC NURSING MENTAL STATUS OBSERVATIONS

Orientation:

see above

Appearance / Grooming:

see above

Mood:

see above

Affect:

☑ Normal ☐ Labile ☐ Flat ☐ Blunted ☐ Manic

Thought Process:

☑ Normal ☐ Loose ☐ Incoherent ☐ Tangenital

Thought Content:

☑ Appropriate ☐ Delusions ☐ Ideas of Reference ☐ Other

Thought Broadcasting:

☐ Obsessive ☐ Phobias ☑ Other ☐ Tangenital

Hallucinations;

☑ None ☐ Visual ☐ Auditory ☐ Tactile ☐ Olfactory

Speech:

see above

Insight:

see above

SYSTEM ASSESSMENT

General:

☐ Weight Change ☐ Fatigue ☐ Malnourished ☐ Fever / Chills ☐ Sleep Patterns ☐ Eating Problems

☑ No Change

Oral Hygiene:

☑ Good ☐ Fair ☐ Poor ☐ No Teeth ☐ Dentures

Visual / Hearing:

☑ No Problem ☐ Glasses ☐ Contacts ☐ Nearsighted ☐ Farsighted ☐ Hearing

CV

☑ No Problem ☐ Diabetes ☐ Palpitations ☐ Pain ☐ Edema ☐ Heart Problem

☐ Hyper / Hypotension

Respiratory:

☑ No Problem ☐ SOB ☐ Asthma ☐ COPD ☐ Smoker

If Smoker, please specify Amount per day

EENT

☑ No Problem ☐ Ringing in Ears ☐ Sore Throat ☐ Frequent Colds ☐ Visual Disturbances ☐ Blurry

☐ Double Vision ☐ Drainage / Pain

GU

☑ No Problem ☐ Incontinence ☐ Frequency ☐ Retention ☐ Pain / Burning ☐ Discharge

☐ Sexually Active ☐ Safe Sex ☐ Contraception

GI

☑ No Problem ☐ Diarrhea ☐ Bloody / Tarry stool ☐ N/V ☐ Constipation ☐ Laxatives

☐ Distension ☐ Heartburn / Indigestion ☐ Ulcers ☐ Pain

CNS

☑ No Problem ☐ Dizziness ☐ Headaches ☐ Head Injury ☐ Coordination ☐ Numbness / Tingling

☐ Take meds for seizures

Seizures (Type):

denies

M/S:

☑ No Problem ☐ Stiffness ☐ Temporary Change ☐ Paralysis ☐ Color Change ☐ Contractures

☐ Arthritis

GYN:

☑ No Problem ☐ LMP ☐ Dysmenorrheal ☐ Discharge ☐ Contraception ☐ PMS ☐ Menopause

If applicable, # Pregnancies:

If applicable, # Live Births:

If applicable, # Last PAP:

Skin:

☑ No Problem ☐ Rash ☐ Lice ☐ Scabies ☐ Abrasion ☐ Bruises ☐ Lacerations ☐ Scars

Location of Skin Problems:

none

Sleep:

"up and down"

Appetite:

"sometimes OK"

Sexual Orientation:

not measured

NUTRITION SCREENING

Does client have a severe food allergy?

○ Yes ◉ No

Food Preferences / Dislikes:

not measured

Special Needs (Texture, Supplements, Cultural/Religious Factors, etc.):

not measured

Does client have a difficulty chewing or swallowing?

○ Yes ◉ No

Has the client experienced a decrease in food intake and/or appetite?

○ Yes ◉ No

Does the client have eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting?

○ Yes ◉ No

Has the client experienced an unintentional weight loss or gain within the last month (10lbs or more for ADULTS and 5lbs or more for CHILDREN)?

○ Yes ◉ No

If Yes to any of the above questions, a recommendation should be made for client to see a healthcare provider on site or referral is to be made.

Dentures:

○ Yes ◉ No

Partial Dentures:

☐ Upper ☐ Lower

Full Dentures:

☐ Upper ☐ Lower

Is the Client currently experiencing Dental Problems?

○ Yes ◉ No

If Yes, a referral to a Dentist should be provided.

COLUMBIA SUICIDE SEVERITY RATING SCALE

1. Do you currently wish to be Dead? Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. "HAVE YOU WISHED YOU WERE DEAD OR WISHED YOU COULD GO TO SLEEP AND NOT WAKE UP?"

○ Yes ◉ No

2. Do you currently have suicidal thoughts? General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. "HAVE YOU ACTUALLY HAD ANY THOUGHTS OF KILLING YOURSELF?" *If yes to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.

○ Yes ◉ No

3. Suicide Behavior Question: "HAVE YOU EVER DONE ANYTHING, STARTED TO DO ANYTHING, OR PREPARED TO DO ANYTHING TO END YOUR LIFE?" Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, tried to hang yourself, etc.

○ Yes ◉ No

If YES, ask: "HOW LONG AGO DID YOU DO ANY OF THESE?"

◉ Over a year ago? ○ Betwen three months and a year ago? ○ Within the last three months?

If yes to any of the above, complete C-SSRS

Additional Information

Remarks

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Service Related Encounter Information

Exempt from Billing	*Activity Type*	*Client Involved*	*Program Providing Service*
No		Yes	BHUCC - BHUCC (00543)

Facility Providing Service	*Encounter With*	*Service Authorization*
00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)		

Signatures

Date	Name	Action	Signature
5/14/2020 8:52 PM	Arrajj, Michael (RN) Registered Nurse (RN)	Submit Event	Michael Arrajj, 310359 RN
5/14/2020 8:55 PM	Arrajj, Michael (RN) Registered Nurse (RN)	Approve Event	Michael Arrajj, 310359 RN

Stars Behavioral Health Group
BHUCC Nursing Admission Note 19.10

Patient Name	Date of Birth	Gender	ID No.
Chaney, Anisa	09/06/1973	F	00072499

GENERAL INFORMATION

Client	Event	Actual Date [PST]	Completed by
Chaney, Anisa	BHUCC Nursing Admission Note 19.10	5/14/2020 4:00 PM	Arrajj, Michael

Submit To

Arrajj, Michael (Registered Nurse (RN))

DEMOGRAPHICS

Gender	SS#	DOB	Age	Ethnicity	Ethnicity Details	Religion	Eye Color	Hair Color	Citizenship	Veteran	Language	Ethnicity Details Standard Code	Special Accomodations Needed
Female	561-39-6450	9/6/1973	48	Unknown / Not Reported						No	English		No

Race	Other
Black or African American	

ENROLLMENT INFORMATION

Program	Program Start Date	Criteria for Admission	Referral Source
BHUCC	5/14/2020 4:00 PM		Physican/ Psychiatrist/ Psychologist/ SW

VITALS

Height (ft and inches)	Weight (lb and oz)	BMI Pct	BMI	Blood Pressure	Pulse	Temperature	Respiration
62	130		0.2	109/61	77	97.7	14

Nursing Admission Note

SITUATION/MEDICAL NECESSITY

REASON FOR ADMISSION:

46 yo AA female self presents with c/os of stress and anxiety. states there have been a number of events and she is "trying to hold it together". Most recently - clt is a nurse, works at a SNF. Around two weeks ago was exposed to coronavirus. Had a test on May 5 that was neg. has no sx of Covid. About 6 years ago her daughter had a breakdown, was unstable for 5 years, but has been better for the last year. Also at that time there was severe marital stress. Clt did not elaborate. Has limited h/o psych Tx. Saw a psychiatrist in 2017. Not known if she was ever treated with medications. MSE: well nourished well developed female, cooperative with interview. No abnormal behavior or movements noted. Speech is soft, normal rhythm and rate, clear. Mood is depressed, affect tearful. T.P: coherent, linear, and goal-directed. Denies VH, AH, or delusions. T.C: denies SI, HI, or h/o same. Seems to be expending a large amount of psychic energy trying to stand up to her challenges. Insight and judgement good

LEGAL STATUS:

vol

APPEARANCE:

see above

UDS:

not measured

BAC:

not measured

HCG:

not measured

INTERVENTION

ACTIVITIES PERFORMED UPON ADMISSION:

medical clearance
nursing admission and assessment

ORIENTATION TO UNIT/STAFF:

Ox4

RESPONSE

CURRENT MENTAL STATUS/BEHAVIORS:

see above

PLAN

EVALUATION PLAN:

to be seen by therapist and possibly provider

Additional Information

Remarks

Confidentiality Statement

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Wand I Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without written authorization of client/authorized representative to who it pertains unless otherwise permitted by law.

Service Related Encounter Information

Exempt from Billing	*Activity Type*	*Client Involved*	*Program Providing Service*
No		Yes	BHUCC - BHUCC (00543)

Facility Providing Service	*Encounter With*	*Service Authorization*
00543 - Star View Urgent Care Center - Long Beach (Lic.# 00543)		

Signatures

Date	Name	Action	Signature
5/14/2020 8:52 PM	Arrajj, Michael (RN) Registered Nurse (RN)	Submit Event	Michael Arrajj, 310359 RN
5/14/2020 8:55 PM	Arrajj, Michael (RN) Registered Nurse (RN)	Approve Event	Michael Arrajj, 310359 RN

Star View Behavioral Health Urgent Care Centers
TRIAGE FORM

Today's Date/Fecha: 05-14-20 **Time of Arrival/Hora:** 0920

First Name/Nombre: Anisa **MI:** M **Last Name/Apellido:** Chaney

Current Residence/Residencia actual: ☐ Home/Casa ☐ Group Home/Acilos ☐ Shelter/Refugios ☐ None/Homeless ☐ Other/Otro ____

Address/Dirección: 13200 Doty Ave #101

City/Ciudad: Hawthorne, Ca **Zip code/Codigo postal:** 90250

Are you able to return to this address? ☒ Yes ☐ No **Phone Number/Teléfono:** 310-413-5025
¿Eres capaz de regresar a esta dirección?

DOB/Fecha de Nacimiento: 09-06-1973 **Age/Años:** 46 **SSN:** 561-39-6450

Sex/Sexo: ☐ M/Hombre ☒ F/Mujer ☐ MTF/MaH ☐ FTM/HaM

Gender Identity/Identidad de Género: ☐ M/Hombre ☐ F/Mujer ☐ Not Sure/No está seguro ☐ Other/Otro: _____

What are your preferred gender pronouns? _____
Cuál es su pronombre preferido de género?

Race/Raza: Black **Preferred Language/Idioma Preferido:** English

Marital Status/Estado Civil: ☐ M/Casado ☐ S/Soltero ☐ D/Divorciado ☐ W/Viudo ☒ SP/Separado

Emergency Contact/Contacto de Emergencia: 310-981-7546 Taylor Chaney **Relationship/Relación:** Daughter

Phone Number (of Emergency Contact)/Teléfono: _____

Who is authorized to consent for person? Self **Relationship/Relación:** _____
¿Quién está autorizado para dar el consentimiento para la persona?

How did you hear about us? (please check one)
¿Como se entero de nuestra agencia? (por favor, marque uno)

- ☐ Other mental health provider/Otro proveedor de servicios de salud mental: _____
- ☒ Medical care provider/Proveedor de servicios médicos: _____
- ☐ Social Service agency (shelter, food bank, etc.)/Proveedor de servicios sociales: _____
- ☐ Law enforcement agency/Cuerpos policiales: _____
- ☐ School/Escuela
- ☐ Friend/Amigo or Family/Familia
- ☐ Billboard/Anuncio cartel
- ☐ Bus poster/Anuncio en autobús
- ☐ Bus stop poster/Anuncio en parada de autobús
- ☐ Walk-in/Cliente sin cita
- ☐ Other/Otro: _____

STOP- Continue on back to Questionnaire/Continuar hacia atrás

---

Nursing Assessment completed ☒ Client is medically cleared ☐ Client will be referred to ER or HLOC

Licensed Nurse Signature & Title: [signature] RN

Printed Name: [illegible] **Date:** 5/14/2020 **Time:** 1045

Rev. 1/1/120

Over for more information →

Star View Behavioral Health Urgent Care Centers
TRIAGE FORM

Please answer the following questions/Por favor, conteste a las siguientes preguntas:

Yes No

- ☐ ☐ Are you currently having chest pains or having trouble breathing?¿Actualmente tiene dolores en el pecho o dificultad para respira
- ☐ ☒ Are you bleeding or have any open wounds right now?¿Estas sangrando o tienes heridas abiertas en este momento?
- ☐ ☒ Have you had a seizure within the last 24 hours?¿Ha tenido un ataque de convulsiones en las últimas 24 horas?
- ☐ ☒ Have you been seen at an emergency room today?¿Te han visto en una sala de emergencia hoy?
- ☐ ☒ Are you pregnant, possibly pregnant or currently breast feeding?¿Estas embarazada, posiblemente embarazada o actualmente amamantando?
- ☐ ☒ Do you have a medical condition, that you are having right now, that we should be made aware of (i.e. high blood pressure, seizure disorder, high blood sugar)?¿Tiene una condición médica que debemos conocer (presión arterial alta, trastorno convulsivo, alto nivel de azúcar en la sangre que está teniendo ahora)?
- ☐ ☒ Do you feel like hurting yourself or anyone else right now?¿Tienes ganas de lastimarte o lastimar a alguien más en este moment
- ☐ ☒ Are you smelling, seeing, hearing or feeling things others don't experience right now?¿Hueles, ves, escuchas o sientes cosas que otros no experimentan en este momento?
- ☐ ☒ Are you in possession of any weapons, drugs or contraband right now?¿Tienes armas, drogas, o contrabando en este momen

If yes, to any of the questions above, stop and return the board to intake for further directions.
Si contesto "Sí" a alguna pregunta anterior, pare y devuelva el cuestionario a la recepción para obtener más instrucciones.

What is going on in your life today, that brought you here? Que está pasando en tu vida hoy, ¿qué te trajo aquí? _____

_____

_____

*Have you experienced any traumatic events in the past? ☒ Yes ☐ No
*¿Has pasado por algún evento traumático en el pasado?

*Have you had any recent thoughts/intent of seriously harming yourself or someone else? ☐ Yes ☒ No
*¿Has tenido algún pensamiento/intención reciente de lastimarte seriamente a ti mismo o a otra persona?

Have you seen a psychiatrist in the past? ¿Has visto a un psiquiatra en el pasado? ☒ Yes ☐ No

If yes, last time seen? ¿Si es así, la última cita fue? 2017

Please explain/Por favor explique: Anxiety | Panic Attack | Stress

_____

Date of last physical exam/Fecha de ultima examen fisico: 10/18

Do you currently take medication?¿Toma medicamento actualmente? ☐ Yes ☒ No

If yes, are your current medications helping you?¿Si está tomando medicamentos psicotrópicos, le están ayudando? ☐ Yes ☐ No

Please explain/Por favor explique: _____

_____

Are you insulin injection dependent? ¿Eres dependiente de la insulina inyectable? ☐ Yes ☒ No

Do you use alcohol or drugs? ¿Usas alcohol o drogas? ☐ Yes ☒ No If yes, last used? Si es así, se usó por última vez? _____

Type/Tipo:_____ Amount/Cantidad:_____

How long have you been using? ¿Cuanto tiempo has estado usando? _____

Do you have any allergies? ¿Tiene alguna alergia? ☐ Yes ☒ No If so, please list/Nótelas aquí:_____

_____

Over for more information →

If you choose not to consent to Telehealth services, the program may be unable to provide you with the convenient and readily available services and services will be rescheduled for a later date and/or a different site.

Benefits & Risks of Telehealth

I understand that I can expect benefits from Telehealth but that no results can be guaranteed or assured. Telehealth provides me access to medical care that otherwise might not have been available in person. Despite reasonable and appropriate efforts, there is the possibility that:

- The transmission of medical information could be disrupted or distorted by technical failures in transmission;
- The transmission of medical information could be interrupted by unauthorized persons (Note: this risk may be increased if I use a Telehealth application that hasn't been vetted and approved by Stars Behavioral Health Group;
- The electronic storage of medical information generated by telehealth service in one or more databases could be accessed by unauthorized persons;
- Telehealth care, treatment and services may not be as complete as in person care;
- Telehealth does not negate or minimize the risks that may be inherent in a medical/mental illness or condition.

I understand that it is impossible to list every possible risk, that my condition many not be cured or improved, and in rare cases, may get worse.

Treatment Services

I agree to take part in Telehealth services offered by STAR VIEW BEHAVIORAL HEALTH URGENT CARE CENTERS to receive my assessment and treatment services. Program staff explained and talked to me about the following:

- Telehealth potential risks and benefits
- Confidentiality of Telehealth services
- How the Telehealth service works
- What we'll do if our Telehealth session gets interrupted and our back up plan
- How we'll handle different situations that could come up during the Telehealth session

I have read and agree to all conditions for treatment and Telehealth set forth herein. I acknowledge that I have received a copy of this agreement.

Client: Anisa Chaney _____ _____
Print Name Signature

Parent/Guardian (if applicable): _____

Staff / Witness _____

For ***verbal consent***, note: _____(date)_____(time).

Staff shall continue to make efforts to obtain written consent

BHUCC
BEHAVIORAL HEALTH URGENT CARE CENTER

STAR VIEW BEHAVIORAL HEALTH URGENT CARE CENTERS
Telehealth Services Consent

Use of Telehealth
Telehealth involves Program staff using technology (internet-connected devices and applications) to video-call you on your internet-connected device (e.g., cell phone, tablet, computer, laptop). Telehealth may be used to provide your assessment and treatment services.

What is Telehealth and how do Telehealth Services work?
Telehealth services are used when the Program staff cannot be physically present with you to provide assessment and treatment services. Telehealth allows you and the Program staff to talk with and see one another using internet-connected devices and video chat applications.

You will be encouraged to participate in the Telehealth session in a private area with minimal disruptions. You may also request to have a friend or family member present just like during an in-person session. The Program staff will be in a private room at another location with a device that has audio and video ability. Program staff will check to make sure the equipment is working properly and that you and the staff can see and hear one another.

Telehealth and Confidentiality
We are dedicated to protecting your confidentiality and the security of your medical information (see Client Notice of Privacy Practices). All existing confidentiality protections apply. All existing laws regarding client access to mental health information and copies of mental health records apply.

There is no permanent video or voice recording kept of the Telehealth session. Client identifiable images or information from the Telehealth interaction shall not occur without the consent of the client or as otherwise permitted by law.

We have identified applications that allow us to meet with you through Telehealth which protect your visual and audio communications with us during that process. We will ask you to use these applications which may require you to download an application onto your device. It will ask you to allow it to connect to your device's speakers and camera just while the Telehealth session is active.

In emergency situations (natural disaster, pandemic, crisis) you might request we use another application that we haven't approved. We will do our best to work with you but won't be able to assure the confidentiality of that Telehealth session if a non-approved app is used. We will ask you to acknowledge these risks and we will document in your record that you understood those risks and consent to the use of non-approved Telehealth applications.

Client Choice
You have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

Star View Behavioral Health
Urgent Care Centers

Consent for Treatment

I consent and agree, voluntarily, to receive mental health services from Star View Behavioral Health Urgent Care Center. These services may include, but are not limited to, diagnostic assessment, crisis intervention, individual, group and/or family therapy; consultations and referrals to/from other behavioral health professionals within Los Angeles County's Department of Mental Health and their contracting agencies.

I understand that by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operation purposes, only.

I understand that this is a non-medical psychiatric facility that can only provide basic first aid. I further understand that if I am having a medical emergency, I need to inform staff immediately so that Emergency Medical Services (911) can be called. Also, I understand that if staff deem the need for emergency medical intervention, 911 will be called.

I understand that the facility may deem it necessary to **inspect my person and my possessions** for items which it considers dangerous to my safety and welfare, or to the safety and welfare of other clients and facility employees. I hereby consent to any such inspection of my person and my possessions which may be made by any qualified BHUCC employee, legally authorized to make such inspections, and release the facility and its employees from any liability or other responsibility for the consequences of such an inspection.

I understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I also understand that I am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

Please be advised that this facility utilizes video surveillance outside of the building as well as throughout the inside of the facility for security and monitoring purposes. The cameras capture video recording. Audio is not recorded. Please let us know if you have any concerns about the use of video surveillance at this facility.

Print Client Name	Signature of Client	Date
Anisa Chaney		5-14-20

Print Responsible Adult's Name*	Responsible Adult's Signature	Date
		5/14/20

Staff's Name	Staff's Signature/Title	Date
Sergio B		

* Responsible Adult = Guardian, Conservator, or Parent of minor

Rev. 12.25.19

Star View Behavioral Health
Urgent Care Centers

Consentimiento al Tratamiento

Yo doy consentimiento y estoy de acuerdo, voluntariamente, para recibir servicios de salud mental de parte de Star View Behavioral Health Urgent Care Center. Estos servicios pueden incluir, pero no se limitan a, la evaluación diagnóstica, la intervención en crisis, la terapia individual, grupal y/o familiar; consultas y remisiones a/de otros profesionales de la salud conductual dentro del Departamento de salud mental del Condado de los Angeles y sus agencias contratantes.

Entiendo que, al dar su consentimiento al tratamiento, la información personal de salud puede ser intercambiada de manera limitada para propósitos de tratamiento, pago y operación de atención médica, solamente.

Entiendo que este es un centro psiquiátrico, no médico, que sólo puede proporcionar primeros auxilios básicos. Además, entiendo que si estoy teniendo una emergencia médica, necesito informar al personal inmediatamente para que los Servicios Médicos de Emergencia (911) puedan ser llamados. Además, entiendo que si el personal considera la necesidad de una intervención inmediata de emergencia, se llamará al 911.

Entiendo que esta instalación puede considerar necesaria inspección a mi **persona** y mis posesiones en busca de **artículos** que se consideran peligrosos para mi seguridad y bienestar, o para la seguridad y el bienestar de otros clientes y los empleados de las instalaciones. Yo doy mi consentimiento a una inspección de mi persona y mis posesiones que pueden ser hechas por cualquier empleado calificado de BHUCC, legalmente autorizado para hacer tales inspecciones, y liberar la instalación y sus empleados de cualquier responsabilidad por las consecuencias de la inspección.

Entiendo que tengo el derecho de negar el tratamiento en cualquier momento. También entiendo que tengo el derecho de declinar cualquier recomendación, intervención psicológica o cualquier procedimiento de tratamiento.

Entiendo que se espera que beneficie del tratamiento, pero no hay garantía implícita o expresa que lo hará.

Tenga en cuenta que esta instalación utiliza videovigilancia fuera del edificio, así como en todo el interior de la instalación para fines de seguridad y monitoreo. Las cámaras capturan la grabación de vídeo. Audio no se graba. Por favor, háganos saber si tiene alguna preocupación sobre el uso de la videovigilancia en esta instalación.

Nombre del paciente	Firma del paciente	Fecha
Nombre del Adulto Responsable*	Firma del Adulto Responsable	Fecha
Nombre del Personal	Firma del Personal	Fecha

*Adulto responsable = Tutor, guardián, cuidador o padre del menor

Rev. 12.25.19

BHUCC
BEHAVIORAL HEALTH URGENT CARE CENTER

Star View Behavioral Health
Urgent Care Center
3210 Long Beach Blvd.
Long Beach, CA 90807
(562) 548- 6565

EMERGENCY SERVICES GUIDE

Welcome to Star View Behavioral Health Urgent Care Centers. To better serve your needs in case of a crisis or psychiatric emergency, we are pleased to provide you with this list of resources. Also, if you have any non-emergency questions or concerns, please feel free, to contact our offices at the numbers listed above.
Program Director: Connelly Jenks

After-hours Emergency Phone:

(562) 548- 6565

Police/Fire/Ambulance: (24 hours daily)
911 or local police
(562) 435-6711

Poison Control: (24 hours daily)
(800) 876-4766

Emergency Psychiatric Assessments: (24 hours daily)
Del Amo Hospital (800) 533-5266
College Hospital (855) 844-8898

Suicide Prevention Hotline: (24 hours daily)
(310) 391-1253 or (800) 273-8255

Trevor Project Hotline (LGBTQ): (24 hours daily)
(866) 488-7386

Crisis Text Line: (24 hours daily)
Text "HOME" to 741741 (standard messaging rates apply)

Local Hospital: (24 hours daily)

Long Beach Memorial Medical Center

(562) 933-2000
2801 Atlantic Avenue
Long Beach, CA 90806

Child Abuse Hotline: (24 hours daily)
Dept. of Children & Family Services
(800) 540-4000

Missing Children Hotline: (24 hours daily)
(800) 222-3463

Patients' Rights Bureau: (24 hours daily)
(800) 700-9996

L.A. County DMH PMRT Crisis 24/7
(800) 854-7771

By signing below, I acknowledge that I have received a copy of this document in addition to the *Los Angeles County Department of Mental Health Grievance and Appeal Procedures- a Consumer's Guide* and *A Guide to Medi-Cal Mental Health Services*, and that further copies are available m the lobby.

Client Signature: [signature] *Date:* 5-14-20

Client Printed Name: Anisa Chavez *MIS#* 7162172

Responsible Adult's Signature: _____ *Date:* _____

Responsible Adult's Name: _____ *Relation to client:* _____

To be competed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the efforts made to obtain the individual's acknowledgement, and the **reasons why the acknowledgment was not obtained:**

Staff Signature: _____ Date: _____

Name & Title: _____

Original m Consumer/Client Copy: EMR Rev. 2/12/19

BHUCC
BEHAVIORAL HEALTH URGENT CARE CENTER

Star View Behavioral Health Urgent Care Centers

3210 Long Beach Blvd. Long Beach, CA 90807

RIGHTS OF PATIENTS (Adults)

Each person voluntarily admitted or involuntarily detained for evaluation or treatment shall have the following rights:

a. To wear his own clothes; to keep and use his own personal possession including toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.
b. To have access to individual storage space for his private use.
c. To see visitors each day.
d. To have reasonable access to telephones, both to make and receive confidential calls.
e. To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
f. To refuse shock treatment.
g. To refuse lobotomy.
h. To see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person.
i. Other rights, as specified by regulation. (Section 5331, Welfare and Institutions Code, State of California)

No person may be presumed incompetent because he or she has been evaluated or treated for a mental disorder or chronic alcoholism, regardless of whether voluntarily or involuntarily received. (Section 5331, Welfare and Institutions Code, State of California)

I hereby acknowledge receipt of a copy of rights of patients as set forth in Sections 53525 and 5331 of the State of California Mental Health Services Act and hereby certify that I understand these rights as printed above. I also affirm that I have been provided with the *California Department of Health Services Rights for Individuals in Mental Health Facilities – Admitted under the Lanterman-Petris Short Act* handbook.

[redacted]: Anisa Chaney

[redacted]: [signature] Date: 5-14-20

Name of Conservator (if applicable): _____

Signature of Conservator (if applicable): _____ Date: _____

To be competed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgment was not obtained:

Staff Signature: _____ Date: _____

Name & Title: _____

MH 710
10/25/13

MEDI-CAL REQUIRED INFORMING MATERIALS
BENEFICIARY ACKNOWLEDGMENT OF RECEIPT

Consistent with regulatory requirements stated in the Code of Federal Regulations §438.10 and the California Code of Regulations §1810.360(e) "The MHP of the beneficiary shall provide its beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service from the MHP or its contract providers."

I. Booklet (Guide to Medi-Cal Mental Health Services)

Select one of the following:

☐ Beneficiary was offered the Guide to Medi-Cal Mental Health Services **upon first receiving services**
☐ **Accepted** ☐ **Declined**

☐ Beneficiary received the Guide to Medi-Cal Mental Health Services **upon request**

Provided in the following language(s)/alternative format(s):
(Check all that apply)

☐	Arabic	☐	Arabic (large print)	☐	Arabic (CD)
☐	Armenian	☐	Armenian (large print)	☐	Armenian (CD)
☐	Cambodian	☐	Cambodian (large print)	☐	Cambodian (CD)
☐	Chinese (Simplified)	☐	Chinese (Simplified large print)	☐	Chinese Simplified (CD)
☐	Chinese (Traditional)	☐	Chinese (Traditional large print)	☐	Chinese Traditional (CD)
☐	English	☐	English (large print)	☐	English (CD)
☐	Farsi	☐	Farsi (large print)	☐	Farsi (CD)
☐	Korean	☐	Korean (large print)	☐	Korean (CD)
☐	Russian	☐	Russian (large print)	☐	Russian (CD)
☐	Spanish	☐	Spanish (large print)	☐	Spanish (CD)
☐	Tagalog	☐	Tagalog (large print)	☐	Tagalog (CD)
☐	Vietnamese	☐	Vietnamese (large print)	☐	Vietnamese (CD)

II. Provider List

Select one of the following:

☐ Beneficiary was offered the Mental Health Plan Provider List **upon first receiving services** ☐ **Accepted** ☐ **Declined**
☐ Beneficiary received the Mental Health Plan Provider List **upon request**

The Provider List options include Service Area Network Providers, Directly-Operated and Contracted Providers

Signature of Client* 5-14-20 Date

Signature of Responsible Adult** Date Relationship to Client

Signature of Staff*** 5/14/20 Date

*** Language (if translated)

* A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
** Responsible Adult = Guardian, Conservator, or Parent of minor when required.
***Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language in which it was interpreted).

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: Anisa Chaney IS#: 716217 0
Agency: Star View Behavioral Health Urgent Care Centers Provider #: 190U
Los Angeles County – Department of Mental Health

BENEFICIARY ACKNOWLEDGMENT OF RECEIPT

Star View Behavioral Health
Urgent Care Centers

CLIENT NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

By signing this form, you acknowledge the receipt of the *Notice of Privacy Practices* of Star View Behavioral Health Urgent Care Centers. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Medical Records Department. For your convenience, our *Notice of Privacy Practices* is also posted on our website at www.starsinc.com and throughout our facility.

If you have any questions about our *Notice of Privacy Practices*, please contact

Director of Quality and Compliance
(310) 221-6336 ex 114

I acknowledge receipt of the *Notice of Privacy Practices* of Star View Behavioral Health Urgent Care Centers.

[redacted]'s Signature: _____ Date: 5/14/20
(patient/parent/conservator/guardian)

[redacted]'s name: Anisa Chaney

Responsible Adult's Signature: _____ Date: _____

Responsible Adult's name: _____

Relationship to patient *(parent/guradian/conservator)*: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT (For office use only)

To be competed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, **describe the efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgment was not obtained:**

Signature: _____ Date: _____

Name & Title: _____

MH 635
Revised 02/15/11

ADVANCE HEALTH CARE DIRECTIVE ACKNOWLEDGEMENT FORM

Background
In accordance with California Probate Code 4600 et seq. and Federal requirements under Title 42, clients 18 years of age and older shall receive information about Advance Health Care Directives and be informed of their right to make decisions about their medical treatment.

To Be Completed by Staff

The client was given a copy of the Advance Health Care Directive Fact Sheet at the first face-to-face contact or clinic visit. ☑ Yes ☐ No

If "No" please explain why the client was not given the Fact Sheet:

Does the client have an Advance Health Care Directive currently in place? ☐ Yes ☑ No

If the client would like to execute an Advance Health Care Directive, please refer them to the resources identified on the Fact Sheet. If a client already has an Advance Health Care Directive, insert a copy into the client's Clinical Record in Section 2 (Consents and Notices).

To Be Completed by the Client/Responsible Adult*

I have been asked about having an Advance Health Care Directive, and I have been given or offered an Advance Health Care Directive Fact Sheet.

[redacted] 5-14-20
Signature of Client Date

Signature of Responsible Adult* Relationship to Client Date

[redacted] 5/14/20
Signature of Witness/Interpreter ** Date

This Form was interpreted in _____ for the client and/or responsible adult.
If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Form on _____ by _____.
Date Initials

* Responsible Adult = Guardian, Conservator, or Parent of minor when required.
** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).

Name: Anisa Chaney IS#: 716278
Agency: Star View BHUCC Provider #: 190U
Los Angeles County – Department of Mental Health

ADVANCE HEALTH CARE DIRECTIVE

Star View Behavioral Health
Urgent Care Centers

Notification of Supervised Counseling from an Associate License-Waivered Therapist

Name of Client: Anisa Charey

Date of Birth: 09/06/1973 Client IBHIS ID#: _____

I understand that by signing below I give consent for the evaluation, treatment, and maintenance of medical and mental health records by a supervised, registered Associate Marriage and Family Therapist, Associate Social Worker, or by a Post-Doctoral Psychology Intern, who has been granted a license waiver by the State Department of Mental Health.

I understand that a Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, or Licensed Psychologist will closely supervise this therapist. I also understand that if I have any questions or concerns regarding any aspect of the assessment, treatment or progress of my case, I can contact this supervisor and have my questions and/or concerns answered and/or resolved.

As this therapist is in training, he/she will discuss the assessment and ongoing treatment of your case and any collateral contacts or meetings in supervision. This amounts to another limit of confidentiality, as it is imperative that this therapist be able to discuss any and all aspects of treatment in supervision.

In an effort to provide the highest quality care, you may periodically receive state and/or other surveys, which will ask for feedback on your satisfaction with the services being provided. In addition, the clinical supervisor that is supervising your assigned therapist may call or meet with you to discuss your services as well.

Your therapist's name is Sean Waldkirch
(Registered Associate Marriage & Family Therapist or Registered Associate Children's Social Worker)

He/She can be contacted at: 562-548-6565

The supervisor of this therapist is: Connelly Jenks

License #:

verbal consent provided — 5/14/2020
Signature of Client — Date

_____ — _____
Signature of Responsible Adult* — Date

_____ — 5/14/2020
Signature of Witness/Staff — Date

Rev 2.15.19

* Responsible Adult = Guardian, Conservator, or Parent of minor

Stars Behavioral Health Group
BHUCC Aftercare Instructions 19.12

Client: Chaney, Anisa **DOB:** 09/06/1973 **Gender:** Female **ID#** 00072499

GENERAL INFORMATION

Client: Chaney, Anisa
Event: BHUCC Aftercare Instructions 19.12
Date completed: 05/14/2020 08:50pm
Completed by: Waldbillig, Sean

ALLERGIES

Known Allergies:

Type	Allergy	Allergy Details
Medications	O	

MEDICATIONS

Current Medications:

Medication	Rationale	Started	Date Discontinued	Frequency	Route	Duration	Dose	Strength	Take/sig	Prescribed by
Ativan 0.5 MG Oral Tablet		5/14/2020			Oral	10 days		0.5 MG	Take one (1) tablet by mouth twice a day, as needed	Achuamang, Irine
Vistaril 25 MG Oral Capsule		5/14/2020			Oral	30 days		25 MG	Take one (1) capsule by mouth twice a day, as needed	Achuamang, Irine

:

Type: *Tipo*
☐ Transfer *Transferir* ☑ **Discharge** *Dar de Alta*

Discharge or Transfer Date and Time: *Tiempo y Fecha de Dar de Alta o Transferir*

5/14/2020

Provisional Discharge Diagnosis or Transfer Diagnosis: *Diagnostico provisional al tiempo de descarga o transferir*

Diagnosis per NP: Generalized Anxiety Disorder

Medications Prescribed: *Medicamentos Prescritos*

All clients recieve informed consent and side effect information at the time of medications prescribed. [Medication | Strength | Dose | Hours to take | Amount send with client]

Todos los clients reciben el consentimiento informado y la informacion sobre los efectos secunderios en el momento de la medicacion prescrita

Prescribed: Ativan 0.5 MG twice daily as needed for ten days and Vistaril 25 MG twice daily as needed for 30 days
Pick up from CVS 3880 W. Rosecrans
Hawthorne, CA

Dietary Requirements: *Requisitos Dieteticos:*

Maintain Healthy Diet as possible

Stars Behavioral Health Group
BHUCC Aftercare Instructions 19.12

Client: Chaney, Anisa **DOB:** 09/06/1973 **Gender:** Female **ID#** 00072499

Rehabilitation Potential: *Potencial de Rehabilitacion*

Prognosis poor, fair, good, excellent - Prognosis may depend on continued treatment
Fair to Good with continued therapy, medication and consideration of leave from work.

Known Behaviors or Symptoms of Mental Disorder: *Comportamientos conocidos/Sintomas de Diagnostico Mental:*

Behaviors consistent with diagnosis.

Follow-up Appointments and Referrals: (Mental Health and Medical) *Citas de Seguimiento y Referencias: (Medical y Salud Mental)*

Follow up with private therapy options provided:
Most locations have multiple therapists
Look into EMDR, but focus on anxiety and stress management therapy as well as grief support.

Additional information provided for FMLA
Discuss taking health leave with PCP.

If in crisis return to BHUCC
3210 Long Beach Blvd.

Discharge or Transfer Destination: *Dar de Alta/Destino de Transferencia*

Back to Family Home

Who is providing transportation? (if applicable) *Quien esta proporcionando transporte?*

Self

Legal Status at time of Discharge or Transfer: *Estado legal al momento de descarga o transferir:*

Click to select N/A

Legal Guardian or Conservator's Name: *Nombre de guardian legal/conservador:*

Include Date and Time notified of Discharge or Transfer

ACKNOWLEDGEMENT

I understand and have received a copy of the above aftercare/transfer instructions, and emergency services guide.
Entiendo y he recibido una copia de las instrucciones de cuidado posterior/transferencia, y guia de los servicios de emergencia.

I understand that I may also designate another person to receive a copy of this aftercare/transfer plan on my behalf. I hereby request and consent to have a copy of this plan released to the person designated below.
Entiendo que tambien puedo designar a otra persona para recibir una copia de las instrucciones de cuidado en mi nombre.

If a designee is identified, identify the designee's relationship to the client and the designee's contact details (address and phone number).
Si es aplicable, identifica el nombre y relacion de la persona designada con direccion de casa y numero de

Stars Behavioral Health Group
BHUCC Aftercare Instructions 19.12

Client: Chaney, Anisa **DOB:** 09/06/1973 **Gender:** Female **ID#** 00072499

telefono.

Designated Person (If applicable):

EMERGENCY SERVICES GUIDE

After-Hours Emergency Phone / *Linea de emergencia despues de horas de oficina*: (562) 548-6565

Local Hospital / *Hospital Local* (24 hours): Long Beach Memorial Medical Center (562) 933-2000, 2801 Atlantic Ave. Long Beach, CA 90806

Police / Fire / Ambulance (24 hours): 911 or local police (562) 435-6711

Poison Control / *Control de veneno* (24 hours): (800) 876-4766

Emergency Psychiatric Assessments / *Evaluacion psiquiatrica de emergencia* (24 hours): Del Amo Hospital (800) 533-5266 College Hospital (855) 844-8898

Suicide Prevention Hotline/ *Linea para impedir suicidio* (24 hours): (310) 391-1253 or (800) 273-8255

Trevor Project Hotline LGBTQ / *Linea al Projecto Trevor* (24 hours): (866) 488-7386

Crisis Text Line / *Linea de crisis via texto* (24 hours): Text "HOME" to 74174 (standard messaging rates apply)

Child Abuse Hotline / *Linea directa de abuso infantil* (24 hours): Dept. of Childrent & Family Services (800) 540-4000 Missing Children Hotline / *Linea directa de ninos perdidos* (24 hours): (800) 222-3463

Patients' Rights Bureau / *Oficina de los derechos de pacientes* (24 hours): (800) 700-9996

L.A. County DMH PMRT Crisis / *Departamento de salud mental del condado de Los Angeles linea de emergencia* (24 hours): (800) 854-7771

I acknowledge that I have received a copy of this document in addition to the Los Angeles County Department of Mental Health Grievance and Appeal Procedures - a Consumer's Guide and A Guide to Medi-Cal Mental Health Services, and that further copies are available m the lobby.

He recibido una copia de este documento y del folleto del condado de Los Angeles - Departamento de Salud Mental sobre procedimientos para quejas y apelaciones - guia para el consumidor, y el Guia Para Servicios de Salud Mental de Medi-Cal y que copias adicionales son disponible en la oficina en la area de recepcion.

ADDITIONAL INFORMATION

Client/Guardian was provided with a copy?: Yes

Stars Behavioral Health Group
BHUCC Aftercare Instructions 19.12

Client: Chaney, Anisa **DOB:** 09/06/1973 **Gender:** Female **ID#** 00072499

Remarks:

CONFIDENTIALITY STATEMENT

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Wand I Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without written authorization of client/authorized representative to who it pertains unless otherwise permitted by law.

Service Related Encounter Information

Exempt from Billing:	
Activity Type:	
Client Involved:	Yes
Program Providing Service:	BHUCC (00543)
Facility Providing Service:	Star View Urgent Care Center - Long Beach (Lic.# 000543)
Encounter With:	
Service Authorization:	

Electronically Signed By:	Date:
Waldbillig, Sean (ASW Lic#ACSW83301) Mental Health Specialist II	5/14/2020 8:58:14 PM

Waldbillig, ASW83301, MHS II

Client Name: Anissa Cheney Date: 5/14/2020

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Emergency Department***

Ask questions that are bolded and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		✓
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
		✓
	Past 3 Months	
If YES, ask: *Was this within the past three months?*		✓

Item 1 Behavioral Health Referral/Full Precautions

Item 2 Behavioral Health Referral/Full Precautions

Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

*If client answers yes to Questions 3-6, **C-SSRS 2 must be completed within 1 hour**

Completed by:

Arrayj

Print Name

Signature

STAR VIEW BEHAVIORAL HEALTH URGENT CARE CENTER
MEDICATION CONSENT AND REVIEW

not required for emergency medication)

I have talked with my psychiatrist or nurse practitioner, I. Achuamang, PNP, who has recommended that I / my child receive(s) medication(s) to treat symptoms of _____.

We have also talked about reasonable alternatives, such as: _____

☐ No reasonable alternatives available at this time.

The type(s) of medications prescribed is identified below:

Medication(s)	Type (Antidepressant, Anxiolytic, Mood Stabilizer, Antipsychotic, Other)	Dosage (including PRN)	Frequency	Method (Oral/Injection)	Duration
1. Ativan	Anxiolytic	0.5mg	BID	PO	x10days
2. Vistaril	Antipsychotic	25mg	BID	PO	x30days
3.					
4.					

- I understand the dosage(s) and when to take the medication(s), and that any changes in medication dosage and or frequency during the course of treatment will be discussed with me.
- I have been informed that some side effects are possible, including:
  - ☑ Muscle stiffness/tremor
  - ☑ Constipation
  - ☑ Dizziness
  - ☑ Weight Gain
  - ☑ Drowsiness
  - ☑ Nausea/appetite changes
  - ☑ Interactions with other drugs, food & health conditions
  - ☐ Other _____
  - ☑ Dry mouth
  - ☐ Sexual problems
  - ☑ Blurred vision
  - ☑ Pregnancy issues
  - ☑ Diabetes
- I understand that these are common side effects, and that there may be other less common ones.
- I also understand that I should promptly inform my psychiatrist or nurse practitioner about changes in my condition (e.g. dizziness, severe sedation, rash), if I become pregnant, and/or any new medications I may be prescribed/take for other conditions.
- **In addition to the above mentioned side effects, I understand there may be additional long term use side effects (present after 3 months)** such as: ☐ None other than those listed above
  ☐ Describe long term side effects not identified above _____
- With some anti-psychotics I understand that there is a possible side effect, tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso and may persist even after stopping the medication.
- I understand that I have the right to refuse mediation
- I understand that the decision to take medication is up to me, but that I should always first discuss with my psychiatrist/nurse practitioner any decision to stop taking medication.
- The likelihood of improving and NOT improving without this medication was discussed with me.

☒ **I HAVE READ THIS FORM** ☐ **THIS FORM HAS BEEN READ TO ME THIS FORM WAS INTERPRETED IN _____ FOR ME.**

If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version

THE INFORMATION ON THE FORM HAS BEEN EXPLAINED TO ME, AND I AGREE TO TAKE THE MEDICATION(S) AS PRESCRIBED. I UNDERSTAND THAT I MAY WITHDRAW CONSENT AT ANY TIME.

Printed Name: Anisa Charey (Client) **Signature:** [signature] Date 5/14/20 Time 21:01

Printed Name: _____ (Parent/Legal Guardian/Conservator) **Signature:** _____ Date _____ Time _____

I HAVE EXPLAINED THE BENEFITS, SIDE EFFECTS AND RISKS OF THE MEDICATION(S) LISTED ABOVE AND HAVE OBTAINED THE PATIENT'S/RESPONSIBLE ADULT'S INFORMED CONSENT.

Signature: [signature], PMHNP (Psychiatrist or Nurse Practitioner and Discipline) **Printed Name:** Linc Achuamang Date 05/14/20 Time 21:01

CLIENT NAME: Anisa Chaney
CLIENT DOB: 09/06/1973
7/6/2172

DATE: 5/14/2020 TIME: 7:30 pm
COMPLETED BY: Sean Waldbillig

PRE-TEST

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Please enter the score for the term which best describes the patient's condition.

0 = not assessed, 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, 7 = extremely severe

1. SOMATIC CONCERN Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not. SCORE: 6	**10. HOSTILITY** Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety, nor somatic complaints. (*Rate attitude toward interviewer under "uncooperativeness"*). SCORE: 1
2. ANXIETY Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms. SCORE: 6	**11. SUSPICIOUSNESS** Brief *(delusional or otherwise)* that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances. SCORE: 1
3. EMOTIONAL WITHDRAWAL Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation. SCORE: 1	**12. HALLUCINATORY BEHAVIOR** Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people. SCORE: 1
4. CONCEPTUAL DISORGANIZATION Degree to which the thought processes are confused, disconnected, or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning. SCORE: 1	**13. MOTOR RETARDATION** Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level. SCORE: 1
5. GUILT FEELINGS Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses. SCORE: 4	**14. UNCOOPERATIVENESS** Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation. SCORE: 1
6. TENSION Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient. SCORE: 5	**15. UNUSUAL THOUGHT CONTENT** Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes. SCORE: 1
7. MANNERISMS AND POSTURING Unusual and unnatural motor benavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here. SCORE: 1	**16. BLUNTED AFFECT** Reduced emotional tone, apparent lack of normal feeling or involvement. SCORE: 1
8. GRANDIOSITY Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation. SCORE: 1	**17. EXCITEMENT** Heightened emotional tone, agitation, increased reactivity. SCORE: 1
9. DEPRESSIVE MOOD Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints. SCORE: 5	**18. DISORIENTATION** Confusion or lack of proper association for person, place or time. SCORE: 1

CLIENT NAME: Anisa Charles
CLIENT DOB: 09/06/1973

DATE: 5/14 TIME: 9:05pm
COMPLETED BY: Sean Waldbillig

7162172 **POST-TEST**

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Please enter the score for the term which best describes the patient's condition.

0 = not assessed, 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, 7 = extremely severe

1. SOMATIC CONCERN Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not. SCORE: 6	**10. HOSTILITY** Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety, nor somatic complaints. (*Rate attitude toward interviewer under "uncooperativeness"*). SCORE: 1
2. ANXIETY Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms. SCORE: 5	**11. SUSPICIOUSNESS** Brief *(delusional or otherwise)* that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances. SCORE: 1
3. EMOTIONAL WITHDRAWAL Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation. SCORE: 1	**12. HALLUCINATORY BEHAVIOR** Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people. SCORE: 1
4. CONCEPTUAL DISORGANIZATION Degree to which the thought processes are confused, disconnected, or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning. SCORE: 1	**13. MOTOR RETARDATION** Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level. SCORE: 1
5. GUILT FEELINGS Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses. SCORE: 5	**14. UNCOOPERATIVENESS** Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation. SCORE: 1
6. TENSION Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient. SCORE: 4	**15. UNUSUAL THOUGHT CONTENT** Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes. SCORE: 1
7. MANNERISMS AND POSTURING Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here. SCORE: 1	**16. BLUNTED AFFECT** Reduced emotional tone, apparent lack of normal feeling or involvement. SCORE: 1
8. GRANDIOSITY Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation. SCORE: 1	**17. EXCITEMENT** Heightened emotional tone, agitation, increased reactivity. SCORE: 1
9. DEPRESSIVE MOOD Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints. SCORE: 5	**18. DISORIENTATION** Confusion or lack of proper association for person, place or time. SCORE: 1

For those 12+ years to ADULT

Client Name: Anisa Vianey Date: 7/14/20

Completed by: Sean Waldbilling

COLUMBIA-SUICIDE SEVERITY RATING SCALE

(C-SSRS) – Part 2* for BHUCC Lifetime/Recent (*Part 1 is completed in EMR)

Types: 1) Wish to be dead: thoughts about a wish to be dead or not alive anymore or wish to fall asleep and not wake up.

2) Non-Specific Active Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

3) Active Suicidal ideation with any methods (NOT PLAN) without intent to act: thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."

4) Active Suicidal ideation with some intent to act, WITHOUT a Specific Plan: Active suicidal thoughts and subject reports having some intent to act on such thoughts, as opposed to "I have the thoughts, but I definitely will not do anything about them."

5) Active Suicidal ideation with Specific Plan and Intent: Suicidal thoughts with details of plan fully/partially worked out and has some intent to carry it out.

If client is currently endorsing #4 or #5 the nurse should inform front desk staff to have client noted in the "client tracker" as a priority. Front desk staff will identify next available MHS or Practitioner and nurse will give report directly to them and ensure they are seen immediately.

INTENSITY OF IDEATION	Lifetime	Recent (1 month)
The following features should be rated with respect to the most severe type of ideation (rating: 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - *Most Severe Ideation:* ____ (Type # (1-5)) ____ (Description of Ideation) Recent - *Most Severe Ideation:* ____ (Type # (1-5)) ____ (Description of Ideation)	Most Severe	Most Severe
Frequency - *How many times have you had these thoughts?* (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	NA	NA
Duration - *When you have the thoughts how long do they last?* (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	—	NA
Controllability - *Could/can you stop thinking about killing yourself or wanting to die if you want to?* (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts		NA
Deterrents - *Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?* (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply		NA
Reasons for Ideation - *What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?* (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply		NA

SUICIDAL BEHAVIOR (Check all that apply, so long as these are separate events; must ask about all types)	Lifetime	Past 3 months
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/desire to die associated with the act, then it can be considered an actual suicide attempt. *There does not have to be any injury or harm*, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you ____ as a way to end your life?*** ***Did you want to die (even a little) when you ____?*** ***Were you trying to end your life when you ____?***	Yes ☐ No ☑ Total # of Attempts ____	Yes ☐ No ☑ Total # of Attempts ____

For those 12+ years to ADULT

Client Name: _____ Date: _____

Or Did you think it was possible you could have died from_____? ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**	Yes ☐ No ☑	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	Yes ☐ No ☑ Total # of interrupted _____	Yes ☐ No ☐ Total # o interrupte _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☑ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # o aborted o self-interrupte _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe	Yes ☐ No ☑ Total # of preparatory acts _____	Yes ☐ No ☐ Total # o preparator acts _____

LETHALITY	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/Firs Attempt Date:
Actual Lethality/Medical Damage: 0 = No physical damage or very minor physical damage (e.g., surface scratches). 1 = Minor physical damage (e.g., lethargic speech, first-degree burns; mild bleeding; sprains). 2 = Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3 = Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4 = Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5 = Death	*Enter Code* NA	*Enter Code* NA	*Enter Cod* NA
Potential Lethality: Only Answer if "Actual Lethality" above = 0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* NA	*Enter Code* NA	*Enter Cod* NA

Identify Protective Factors
(Protective Factors may not counteract significant acute suicide risk factors)

Internal:	External:
☐ Ability to cope with stress	☑ Cultural, spiritual and/or moral against suicide
☐ Frustration Tolerance	☑ Responsibility to children
☑ Religious beliefs	☐ Beloved pets
☐ Fear of death or the actual act of killing self	☑ Supportive social network of family or friends
☑ Identifies reasons for living	☐ Positive therapeutic relationships
	☐ Engaged in work or school

Other Protective Factors:

This Form was interpreted in _____ for the client and/or responsible adult; OR ☐ N/A

Signature of Staff Interpreter | Staff Printed Name | Date

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

PAYER FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1 CLIENT NAME: Anisa Chaney | SS # 561-39-6450 | DMH CLIENT ID #: 7162172

2 MAIDEN NAME: N/A | DOB: 9/6/73 | MARITAL STATUS: ☐M ☐S ☐D ☐W ☒SP | SPOUSE NAME:

THIRD PARTY INFORMATION

3 NO THIRD PARTY PAYER ☐ Issue Date: N/A

4 MEDI-CAL: ☐ YES ☒ NO | MEDI-CAL COUNTY CODE (AID CODE/ CIN #: N/A | MEDI-CAL PENDING: ☐ YES ☒ NO | REFERRED FOR ELIGIBILITY ASSESSMENT: ☐ YES ☒ NO | DATE REFERRED: N/A

5 SHARE OF COST: ☐ YES ☒ NO | SOC AMT: $ 0 | SSI PENDING: ☐ YES ☒ NO | SSI APPLICATION DATE: N/A | IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON: N/A

6 CALWORKS: ☐ YES ☒ NO | GROW: ☐ YES ☒ NO | HEALTHY FAMILIES: ☐ YES ☒ NO | HEALTHY FAMILIES CIN #: N/A | AB3632: ☐ YES ☒ NO | AB3632 CONSENT FORM SIGNED: ☐ YES ☒ NO

7 MEDICARE: ☐ YES ☒ NO | MEDICARE #: N/A | LIFETIME AUTHORIZATION SIGNED: ☐ YES ☒ NO | MEDI-GAP: ☐ YES ☒ NO | VET/ADM: ☐ YES ☒ NO | CHAMPUS: ☐ YES ☒ NO | HEALTHY WAY LA: ☐ YES ☒ NO | HWLA MEMBER #: N/A

8 HMO/PPO: ☐ YES ☒ NO | NAME OF CARRIER: N/A | GROUP/POLICY/ID #: N/A | NAME OF INSURED: N/A

9 CARRIER ADDRESS: N/A | ASSIGNMENT/RELEASE OF INFORMATION OBTAINED: ☐ YES ☒ NO

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10 NAME OF PAYER: N/A | RELATION TO CLIENT: N/A | DOB: N/A | MARITAL STATUS: ☐M ☐S ☐D ☐W ☐SP | PAYER CDL/CAL ID: N/A

11 ADDRESS: N/A | CITY: N/A | STATE: N/A | ZIP CODE: N/A | TEL #: N/A

12 SOURCE OF INCOME: ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐ OTHER: N/A | PAYER SS #: N/A

13 EMPLOYER: N/A | POSITION: N/A | IF NOT EMPLOYED, DATE LAST WORKED: N/A

14 EMPLOYER'S ADDRESS (Include City, State & Zip Code): N/A | TEL #: N/A

15 SPOUSE: N/A | ADDRESS (Include City, State & Zip Code): N/A | SPOUSE'S SS #: N/A

16 SPOUSE'S EMPLOYER: N/A | POSITION: N/A | IF NOT EMPLOYED, DATE LAST WORKED: N/A

17 SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code): N/A | TEL #: N/A

18 NEAREST RELATIVE/RELATIONSHIP: N/A | ADDRESS (Include City, State & Zip Code): N/A | TEL #: N/A

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS		20 ALLOWABLE EXPENSES		21 ADJUSTED MONTHLY INCOME	
Savings	$ 0	Court ordered obligations paid monthly	$ 0	Gross Monthly Family Income	
Checking Accounts	$ 0	Monthly child care payments (necessary for employment)	$ 0	Self/Payer	$ 0
IRA, CD, Market value of stocks, bonds and mutual funds	$ 0	Monthly dependent support payments	$ 0	Spouse	$ 0
TOTAL LIQUID ASSETS	$ 0	Monthly medical expense payments	$ 0	Other Cash Aid	$ 0
Less Asset Allowance	$ 0	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security)	$ 0	TOTAL HOUSEHOLD INCOME	$ 0
Net Asset Valuation	$ 0			TOTAL FROM BOX 19	$ 0 +
Monthly Asset Valuation (Divide Net Asset by 12)	$ 0	Total Allowable Expenses	$ 0	SUBTOTAL	$ 0
VERIFICATION OBTAINED ☐ YES ☒ NO		VERIFICATION OBTAINED ☐ YES ☒ NO		LESS TOTAL FROM BOX 20	$ 0 -
				Adjusted Monthly Income	$ 0
				VERIFICATION OBTAINED ☐ YES ☒ NO	

22 Number Dependent on Adjusted Monthly Income (Client included): 0 | ANNUAL LIABILITY: 0 | ANNUAL CHARGE PERIOD FROM 5/14/2020 TO 5/13/2021 | Payment Plan $ 0.00 per month for 1 2 3 4 5 6 months.

23 PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person): N/A

OTHER

24 PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD ☐ YES ☒ NO WHERE: N/A | FROM: N/A | TO: N/A | PRESENT ANNUAL LIABILITY BALANCE: N/A

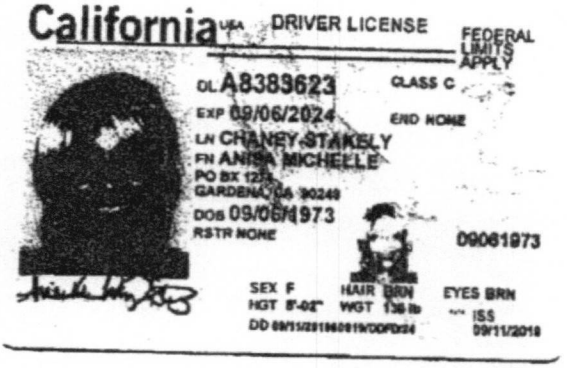
25 ANNUAL LIABILITY ADJUSTED BY: N/A | DATE: N/A | REASON ADJUSTED: N/A
ANNUAL LIABILITY ADJUSTMENT APPROVED BY: N/A | DATE: N/A

26 An explanation of the UMDAP liability was provided.
SIGNATURE OF INTERVIEWER | PROVIDER NAME AND NUMBER: Star View Behavioral Health Urgent Care Center 190U

27 I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22
SIGNATURE OF CLIENT/RESPONSIBLE PERSON | DATE: 5-14-20

MH 281 Rev. 02/11/2011

0067


California USA DRIVER LICENSE

FEDERAL LIMITS APPLY

DL A8383623 CLASS C

EXP 09/06/2024 END NONE

LN CHANEY-STAKELY

FN ANISA MICHELLE

PO BX 123

GARDENA CA 90249

DOB 09/06/1973

RSTR NONE

09061973

SEX F HAIR BRN EYES BRN

HGT 5'-02" WGT 136 lb ISS 09/11/2018

DD 09/15/2018019/DDFD24