WBS

Wayne Behavioral Service, LLC

Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

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MEMBER CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Member Name) give permission to Wayne Behavioral Service, LLC and my

Primary Care Physician (PCP) _____ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, NOT including the results of blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

I can choose to revoke this consent at any time.

_____ _____
Member/Guardian/Authorized Representative - Printed Date

_____
Member/Guardian/Authorized Representative - Signed

_____ _____
Witness – Print & Sign Date

MEMBER REFUSAL TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Member Name) **DO NOT** give permission to Wayne Behavioral Service, LLC

and my Primary Care Physician (PCP) _____ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, including the results of blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Member/Guardian/Authorized Representative - Printed Date

_____
Member/Guardian/Authorized Representative - Signed

_____ _____
Witness – Print & Sign Date

I can choose to revoke this consent at any time.

SELF-ASSESSMENT FORM

Please Print

Name:			Date:
Street:			Suite/Apt. #:
City:	State:	Zip Code:	County
Mark an 'X' in the preferred method of contact			
Phone (home): ☐	Phone (cell): ☐	Phone (work): ☐	
Age:	**Patient's Date Of Birth (Month/Day/Year):**		
Patient's SS#:			
Email Address:			

Name of Person with whom you live:	Relationship:	
Name of person to call in an emergency:	Relationship:	
Street:		Suite/Apt. #:
City:	State:	Zip Code:
Phone (home):	Phone (cell):	
Name of person filling out this form (if not patient):		
Relationship to patient:		

For Office Use Only

☐ New Patient ☐ New Case ☐ Hours ☐ ICANotes ☐ Pharmacy ☐ PaperVision

Chart ID: _____

REFERRAL INFORMATION		
Name of referring patient or responsible physician/clinician:		
Street:	Suite/Apt. #:	
City:	State:	Zip Code:
Phone (work):		

Check those that apply.

RACE
☐ **American Indian or Alaska Native** – Print origin(s), for example, Navajo, Blackfeet, Inupiat, Yup'ik, or Central American Indian groups or South American Indian groups, etc.
☐ **Asian** – Print origin(s), for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.
☐ **Black or African American** – Print origin(s), for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Ghanaian, etc.
☐ **Native Hawaiian or Other Pacific Islander** – Print origin(s), for example, Native Hawaiian, Samoan, Guamanian or Chamorro, Tongan, Fijian, Marshallese, Palauan, Pohnpeian, Chuukese, Yapese, etc.
☐ **White** – Print origin(s), for example, German, Irish, English, Italian, Lebanese, Egyptian, etc.
☐ **Arab-American**
☐ **Indian/Pakistani**

☐ **Hispanic/Latino**

☐ **Some other race or origin**

RELIGION	
☐ Evangelical Protestant	☐ Baptist
☐ Protestant	☐ Jewish
☐ Catholic	☐ Muslim
☐ Orthodox Christian	☐ Buddhist
☐ Greek Orthodox	☐ Hindu
☐ Russian Orthodox	☐ Atheist
☐ Mormon	☐ Agnostic
☐ Jehovah's Witness	☐ Don't Know
☐ Other Christian	☐ Decline to Answer

RESIDENCE			
☐ House	☐ Apartment	☐ Rented Room	☐ Dormitory
☐ Condo	☐ Townhouse	☐ Hospital (Print Name):	
☐ Co-op Living	☐ Hotel	☐ Other	
Nursing Home (Print Name):			

Gender	Marital Status	
☐ Female ☐ Male ☐ Transgender	☐ Never Married ☐ Married ☐ Living Cooperatively	☐ Divorced ☐ Process of Divorcing ☐ Legally Separated/Separated
	If married, how many times? 1 2 3 Other_____	If divorced, how many times? 1 2 3 Other_____
	☐ Marriage annulled	☐ Widow/widower ☐ Other _____

Occupation	Student
	F/T or P/T circle one

Education (please specify highest level completed)		
High school and earlier (circle one) 6th or earlier 7th 8th 9th 10th 11th 12th	College/university (circle one) 1 2 3 4 5 Other_____ Student	Graduate school (circle one) BA BS MA MS MBA PHD Other_____ MD JD
☐ Technical School	☐ Trade School	☐ Certificate Program
☐ GED		

Please state the principal reason you are requesting a consultation or treatment.

If necessary, use another sheet of paper.

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medications and your response to them.

If necessary, use another sheet of paper.

Medical History

Weight and Height

What is your current weight in pounds? _____ lbs.
☐ Check if your weight has increased or decreased by more than 10 pounds during the last 5 years
If checked, explain circumstances.
What is your height in inches? _____ in.

Sleep

Check if you -
☐ have difficulty falling asleep
☐ have difficulty waking up and falling back to sleep
☐ are tired on waking
☐ have bad dreams, wet bed, sleepwalk or other sleep disturbances

Smoking

☐ Check if you smoke.
If checked, how much and for how long?

Caffeine

☐ Check if you drink coffee, tea or colas.
If checked, how much?
☐ Check if you believe you are sensitive to caffeine.

Allergies

List all allergies. Be sure to include medication allergies.

Medical Problems

Age when first occurred	List all past and present medical problems as well as any surgery or accidents.

Females – Menstrual History

☐ Check if your periods are irregular.
If checked, explain.

What is the duration of your periods?

What is the date of your last period?

☐ Check if your periods are irregular.
If checked, explain. Check if there is any pain or discomfort with your periods.

☐ Check if your moods, depression, irritability, or irrationality change with your periods?
If checked, how?

☐ Check if you are taking an oral contraceptive.
If checked, which one and for how long?

☐ If taking an oral contraceptive, check if it affects your mood.

Suicide	Drinking (Alcohol Use)
☐ Check if you have ever thought about suicide. If "yes," when was the last time? ☐ Check if you have ever attempted suicide. If "yes," when and how? ☐ Check if you have thoughts about suicide now.	How many drinks do you consume in the average day? At what time of day do you have your first drink? What is the most you have had to drink in a 24-hour period during the last year? ☐ Check if you ever felt that you were, or someone told you that you were, drinking too much? If "yes," under what circumstances?
Injury to Others	**Drugs of Abuse** **Check if you have taken any of the following drugs.**
☐ Check if you have ever thought about hurting someone else. If "yes," when was the last time? ☐ Check if you have ever hurt someone else. If "yes," when and how? ☐ Check if you are thinking about hurting someone now.	☐ None ☐ Marijuana ☐ Amphetamines/speed ☐ Heroin/opiates ☐ PCP ☐ LSD/hallucinogens ☐ Cocaine/crack ☐ Barbiturates/sedatives/downers If you checked one or more of the drugs, under what circumstances did you take it (them)? When did you most heavily use drugs? When was the last time you took such drugs?
Recent Stressful Life Events **Check any of the following events that have occurred during the last 2 years.**	**Personal History** **Check any items that apply to you and explain.**
☐ Married ☐ Engaged ☐ Separated ☐ Divorced ☐ Serious argument ☐ Breakup of important relation ☐ Child left home ☐ Death of spouse, other ☐ Bad health (behavior) of family member ☐ Difficulties with family member ☐ Personal injury, illness ☐ Sexual difficulties ☐ Difficulties, changes at school, work ☐ Retired, lost job ☐ Changed residence ☐ Legal difficulties, multiple traffic tickets ☐ Owe money	☐ Mother's pregnancy with you was normal ☐ Mother's delivery of you was abnormal Check if during childhood you - ☐ were afraid to go to school ☐ had difficulty w/ reading, writing or arithmetic/math ☐ were truant ☐ failed or repeated a grade ☐ bad frequent falls ☐ were awkward at games ☐ wet bed after age 5 ☐ had tics ☐ had trouble with eyes ☐ were (are) left handed ☐ mispronounced words, had a lisp, stutter/stammer ☐ had nightmares, disturbed sleep, fear of the dark ☐ ran away from home ☐ were cruel to animals ☐ often lied to families or others ☐ set fires ☐ moved often ☐ were exposed to incest ☐ were promiscuous

Family History				Major Illnesses	
Name		Age[a]	Occupation[b]	List all major illnesses, including psychiatric, neurological, alcoholism, drug abuse, suicide, and suicide attempts.	
Mother					
Father					
Brothers					
Sisters					
Children					
Grandparents, uncles, and aunts (relationship)					

[a]Or if deceased, age at death.
[b]Or if deceased, cause of death

Informed Consent for Treatment

I, _____, agree and consent to participate in
PLEASE PRINT
behavioral health services offered and provided at **Wayne Behavioral Service, LLC**; a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within (1) The scope of the provider's license, certification and training or (2) the scope of license, certification and training of the behavioral health care provider directly supervising the services received by the patient. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of the individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____

Signature of responsible party Date

_____

Relationship to patient (if applicable)

Wayne Behavioral Service, LLC
401 Hamburg Turnpike, Suite 302
Wayne, NJ 07470

EMAIL CONSENT FORM

Printed name: _____

Patient e-mail address: _____

PLEASE PRINT CLEARLY

1. RISK OF USING E-MAIL

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail.
These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper an electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an email.

d. E-mail is easier to falsify than handwritten or signed documents
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h. E-mail can be used to introduce viruses into computer systems
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.

b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.
d. If the patient's e-mail requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
f. The patient is responsible for informing Provider of any types of information the patient does not want to besent by e-mail, in addition to those set out in 2(e) above.

g. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform Provider of changes in his/her email address.
c. Put the patient's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
e. Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider.
f. Inform Provider that the patient received an e-mail from Provider
g. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to Provider.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

_____

Patient signature

_____

DATE

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

1. Permission to Use and Disclose My Health Information. By signing this form, I give Wayne Behavioral Service, LLC permission to use and/or disclose my health information to carry out treatment, payment or health care operations.

2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent, Wayne Behavioral Service, LLC will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.

3. Right to Review Notice of Privacy Practices. Wayne Behavioral Service, LLC has provided me with a copy of their Notice of Privacy Practices which describes how Wayne Behavioral Service, LLC may use and disclose my health information. I have the right to review this Notice before signing this consent.

4. Changes to the Privacy Notice. Wayne Behavioral Service, LLC may change the Notice of Privacy Practices as needed. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing.

5. Right to Request Restrictions on Use/Disclosure. I have the right to request that Wayne Behavioral Service, LLC restrict how they use and/or discloses my PHI for the purpose of providing treatment, obtaining payment for services, and/or conducting health care operations. Wayne Behavioral Service, LLC is *not required* to agree to any restriction I request. If Wayne Behavioral Service, LLC does decide to agree to my request, they must restrict their use and/or disclosure of my PHI the way I asked. Because of the number, complexity, and nature of the services they deliver, Wayne Behavioral Service, LLC will rarely agree to requests to restrict uses and disclosures of my PHI for the purposes of treatment, payment, and healthcare operations. If I wish to request restrictions I can contact Cindy O'Donnell, Office Manager. Wayne Behavioral Service, LLC will notify me of the decision to accept or decline my restrictions.

6. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact the Office Manager, Wayne Behavioral Service, LLC, 401 Hamburg Tpke, Suite 302, Wayne, NJ 07470. Note that my withdrawal of this consent will *not* be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Wayne Behavioral Service, LLC, by law, is unable to provide to me further treatment or follow-up, other than required emergency services.

7. Effective Period. This consent is good unless and until I withdraw it in writing.

8. References to "I" or "me". References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the individual.

Patient Name: _____(please print)

Patient or Authorized Representative's Signature:_____

Authorized Representative's Relationship to Patient: _____(please print)

Date:_____

WAYNE BEHAVIORAL SERVICE, LLC
401 Hamburg Turnpike, Suite 302
Wayne, New Jersey 07470
Tel: 973-790-9222 • Fax: 973-790-0671
www.WayneBehavioral@yahoo.com
frontdesk_wbs@yahoo.com

Upload Insurance Card

Patient Information

Name:_____

Date of Birth: _____

Address: _____

_____

Policy Holder Information

Name:_____

Date of Birth: _____

Address: _____

_____

E-Prescribing Form

'X' The Doctor or Nurse Practitioner you see

Dr. Mohamed Elrafei
Dr. Igor Gefter
Dr. Anna Kravtsov
Dr. Leonid Kapulsky
Dr. Emad Mounir
Dr. Marina Haghour-Vwich
Dr. Ruby Kapadia

Dr. Mary Switala, DNP
Dr. Amanda Moroz, DNP
Emily Coyle, PMHNP BC
Maripat Alger-Cottone,APN
Mohamed Alhennawy, PMHNP
Deborah Eid, PMHNP BC
Rupinder Kaur, PMHNP BC

Carrie Prakope, PMHNP BC
Mazie Trusty, PMHNP BC
Natasha Dillon, PMHNP BC
Jessica Miglin, PMHNP BC
Teresa Omwenga, PMHN BC
Lillian Carnero, PMHNP BC
Andrea Torres, PMHNP BC
Lina Muthoni, PMHNP BC

Patient Name: _____

_____

Date: _____

Local Pharmacy Name & Address:

_____

_____

_____

Telephone # _____

Mail Order Pharmacy Name & Address

_____

_____

_____

Telephone # _____

List medications you are allergic to:

No known drug allergies

_____

_____

_____

_____

_____

_____

_____

List current medications:

None

_____

_____

_____

_____

_____

_____

_____

WAYNE BEHAVIORAL SERVICE, LLC
401 Hamburg Turnpike, Suite 302
Wayne, New Jersey 07470
Tel: 973-790-9222 • Fax: 973-790-0671
www.WayneBehavioral@yahoo.com
frontdesk_wbs@yahoo.com

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, WBS reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. The fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing the below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

CREDIT CARD ON FILE POLICY

At Wayne Behavioral Service, LLC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

I (we), the undersigned, authorize and request that Wayne Behavioral Service charge my credit card for the balance due that my health plan has identified as my financial responsibility. This authorization relates to all charges not covered by my insurance company for services provided to me by Wayne Behavioral Service. My card will remain securely stored for future use. This authorization will remain in effect until revoked by me in writing.

I authorize Wayne Behavioral Service, LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **American Express** ☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Credit Card Number _____

Expiration Date ____ / _____ **4- digit security code/ 3-digit AMEX _____**

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Wayne Behavioral Service, LLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization relates to all payments not covered by my insurance company for services provided to me by Wayne Behavioral Service, LLC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Wayne Behavioral Service, LLC in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

Name: _____ Date: _____

GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems? (Circle to indicate your answer)	Not at all	Several days	More than Half the days	Nearly Every day
1. Feeling nervous, anxious or on Edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	_____ +	_____ +	_____ +	_____

For office coding: Total Score _____

Name _____ Date _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

WAYNE BEHAVIORAL SERVICE, LLC

401 Hamburg Turnpike, Suite 302
Wayne, New Jersey 07470
Tel: 973-790-9222 • Fax: 973-790-0671

MEDICAL RECORDS RELEASE/REQUEST

Date: _____

Patient Name: _____

D.O.B.: _____

Address: _____

_____

Signature: _____

I, _____, hereby authorize Wayne Behavioral Service, LLC at 401 Hamburg Turnpike, Suite 302, Wayne, New Jersey 07470 to release/request my
circle one
complete medical records of any reports, notes, evaluations or histories to/from:
circle one

Name: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

Restrictions:

_____

_____

_____

WAYNE BEHAVIORAL SERVICE, LLC

401 Hamburg Turnpike, Suite 302
Wayne, New Jersey 07470
Tel: 973-790-9222 • Fax: 973-790-0671

INFORMATION RELEASE FORM

Please Print

Patient Name: _____

D.O.B.: _____

Address: _____

_____

I, _____, hereby authorize Wayne Behavioral Service, LLC, at 401 Hamburg Turnpike, Suite 302, Wayne, New Jersey 07470 to speak with

_____
PRINT NAME AND RELATIONSHIP

regarding my condition and/or to obtain further information regarding my condition.

Address: _____

_____

Telephone Numbers: _____ or _____

Restrictions:

_____

_____

_____

Signature: _____

Date: _____

OCD Identification Tool

People with OCD experience repetitive and intrusive thoughts, images, urges, or feelings that can be uncomfortable to share. Please answer these questions to see if you might benefit from OCD treatment.

Name	Date of Birth	Insurance

☐ Yes
☐ No

I have frequent thoughts, urges, or images that I don't want to have.

For example . . .

- Being contaminated even though I may not be
- Acting out sexually, in a way that's against my character
- Having thoughts that violate my religious beliefs, or thoughts that I may hurt someone else, even though I don't want to, that trouble me

☐ Yes
☐ No

I do repetitive behaviors.

For example . . .

- Hand washing or cleaning
- Ordering or arranging
- Checking things
- Avoiding certain people or things
- Searching for answers online
- Asking people for reassurance
- Repeating behaviors over and over
- I repeatedly do things in my mind in order to feel better or to prevent something bad from happening that is problematic, such as
  - Counting
  - Reviewing past events
  - Reassuring myself in my head
  - Saying certain words or phrases

☐ Yes
☐ No

Over the last month, these obsessive thoughts and/or compulsive behaviors have resulted in:

- Noticeable distress or interfered with my functioning at home, work, school, socially, in my relationships, or in any other significant manner, and/or consumed more than an hour of my time daily?

☐ Yes
☐ No

If you answered yes to two or more of the above questions, you may benefit from a conversation about OCD.

Please indicate to your provider if you have an interest in receiving an assessment from an OCD specialist to further evaluate your symptoms.

Y/N Provider recommends ERP Treatment based on conversation with patient

Provider Notes: Why or why not?