Appendix B: Forms and Policies

Snapshots of a Child
1. Portable Medical Summary
2. Getting to Know My Child

Release of Information Forms
3. Massachusetts Department of Public Health Release of Information
4. Massachusetts Behavioral Health Partnership Release of Information
5. Massachusetts Department of Mental Health Two-Way Release of Information
6. HIPAA/FERPA Exchange of Information

Referral and Feedback Forms
7. Early Childhood Developmental Interagency Referral Communication Form
8. School Re-entry Form After Hospitalization

Policies
9. Boston Public Schools Student Health Policy
10. Got Transition Policy
11. Holyoke Pediatric Associates Transition Policy

Checklists
12. Health Care Transition Checklist
1. Portable Medical Summary

Source: the Center for Medical Home Improvement, Used with permission from Got Transition, the National Health Care Transition Center which is supported by a cooperative agreement U39MC18176  HRSA/ US MCHB.

This Portable Medical Summary includes space for recording information about a child/youth, along with identification of specialty providers, schools, community-based providers and their contact information.
**Appendix B: Forms and Policies**

**Portable Medical Summary**

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Portable Medical Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Completed</td>
<td>Date Revised</td>
</tr>
<tr>
<td>Child’s Name</td>
<td>Nickname</td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Parent (Caregiver)</td>
<td>(Relationship)</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone # (home)</td>
<td>Blocked? Y ☐ N ☐ Best Time to Reach</td>
</tr>
<tr>
<td>E-Mail</td>
<td></td>
</tr>
<tr>
<td>Emergency Contact</td>
<td>Phone</td>
</tr>
<tr>
<td>Health Insurance/Plan</td>
<td>Identification #</td>
</tr>
<tr>
<td>Diagnose(s): Primary:</td>
<td>Secondary:</td>
</tr>
<tr>
<td>Emergency Plan</td>
<td>Yes ☐ Not Applicable ☐</td>
</tr>
</tbody>
</table>

**Allergies**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reactions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICATIONS:**

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>MEDICATION</th>
<th>DOSE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SPECIALISTS:**

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>HOSPITAL</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vital Sign (baselines):**

<table>
<thead>
<tr>
<th>Ht</th>
<th>Wt</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Problem List and recommended actions** (check all that apply, please explain in space below):

<table>
<thead>
<tr>
<th>Problem</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Behavioral</td>
<td></td>
</tr>
<tr>
<td>☐ Communication</td>
<td></td>
</tr>
<tr>
<td>☐ Feed &amp; Swallowing</td>
<td></td>
</tr>
<tr>
<td>☐ Hearing/Vision</td>
<td></td>
</tr>
<tr>
<td>☐ Learning</td>
<td></td>
</tr>
<tr>
<td>☐ Orthopedic/Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>☐ Physical Anomalies</td>
<td></td>
</tr>
<tr>
<td>☐ Sensory</td>
<td></td>
</tr>
<tr>
<td>☐ Stamina/Fatigue</td>
<td></td>
</tr>
<tr>
<td>☐ Respiratory</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

**TO BE AVOIDED:**

<table>
<thead>
<tr>
<th>☐ Medical Procedures</th>
<th></th>
</tr>
</thead>
</table>
Appendix B: Forms and Policies

Activities:

Foods:

PRIOR SURGERIES/PROCEDURES:

#1       Date
#2       Date
#3       Date

MOST RECENT LABS/DIAGNOSTICS (AS APPROPRIATE):

<table>
<thead>
<tr>
<th>TEST</th>
<th>DATE OF PROCEDURE</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LABWORK (Specify)</td>
<td></td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRUG LEVELS (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EEG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-Spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI/CT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EQUIPMENT/APPLIANCES/ASSISTIVE TECHNOLOGY:

- Gastrostomy
- Adaptive Seating
- Wheelchair
- Tracheostomy
- Communication Device
- Orthotics
- Suction
- Monitors
- Crutches
- Nebulizer
- Apnea
- O2
- Walker
- Other
- Cardiac
- Glucose
- Other

SCHOOL/COMMUNITY INFORMATION:

AGENCY/SCHOOL/CHILD CARE

CONTACT INFORMATION

Contact Person: Phone:
Contact Person: Phone:
Contact Person: Phone:

FAMILY INFORMATION:

★ SPECIAL CIRCUMSTANCES/COMMENT/FAMILY/YOUTH WANTS US TO KNOW★:

Parent/Caregiver Signature       Date

Primary Care Provider Signature  Print Name  Contact Info  Date

Care Coordinator Signature       Print Name  Contact Info  Date
2. Getting to Know My Child

Source: a parent

This form can be used by families to create a ‘picture’ of the child and use it for sharing information with their child’s providers and/or school, to help these providers better understand the child.
Getting to Know My Child

child's name

parent/guardian

e-mail

Daytime Telephone:

My Child’s Strengths Are

My Child’s Interests / Activities Are

My Child’s Challenges Are

Hints for Working with my Child

The information on this page is written to help you work with and enjoy our child. Thank you for taking the time to read this. It can make all the difference for him/her.
3. Massachusetts Department of Public Health Release of Information

Source: the Massachusetts Department of Public Health

This form includes space for youth and families to indicate a time limit on the permission, the information to be shared, by whom and with whom.
Appendix B: Forms and Policies

Massachusetts Department of Public Health
Authorization for Release of Information
Permission to Share Information

If you want the _____________________ to share information about you with another person or organization, please make sure that you fill out all the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, _____________________ (print your name) _____________________ (Fill in name of person or organization) give my permission for _____________________ (Fill in name of person or organization) to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information
Please describe the information you want the _____________________ (Fill in name of person or organization) to share about you.

Please include any dates and details you want to share.


B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

___ I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

___ I specifically give permission, as required by M.G.L. c. 111, § 70G, to share information in my record about my genetic information.

___ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information
Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: “at my request,” if you are initiating the request.


SECTION IV – Who May Share This Information
I give permission to the person or organization listed below to share the information I listed in Section II:

Name

Organization

Address

HIPAA-compliant Authorization 908 Form 5-A
Massachusetts Department of Public Health
Authorization for Release of Information

SECTION V – Who May Receive My Information
The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

Name

Organization

Address

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts
This permission to share my information is good until ______________ Indicate date or event

If I do not list a date or event, this permission will last for one year from the date it is signed.

• I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to ______________ (Fill in name of person or organization) and send it or bring it to the place where I am now giving this permission (or fill in specific location). If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

• I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

• I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature
Please sign and date this form, and print your name.

Your Signature Date

Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: __________________________________________

Signature of the person filling out this form: __________________________________________

Describe how this person has legal authority for this individual: _________________________________________
4. Massachusetts Behavioral Health Partnership Release of Information

Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

Source: the Massachusetts Behavioral Health Partnership website, MassHealth, and its contracted health plans.

This form is designed to support communication between behavioral health care and primary care providers and includes space to enter information about a child.
### Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

**Health Plan:** Boston Medical Center HealthNet Plan / Network Health / Fallon Community Health Plan / Neighborhood Health Plan / PCC Plan / HNE

The member below is currently receiving services and has consented to share the following information between his/her PCP and BH provider:

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information:

**Member Name:** __________________________

**DOB:** __________________________

**Member ID #:** __________________________

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: __________________________

---

**Section A: (completed by BH Provider)**

1. **The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)**

<table>
<thead>
<tr>
<th>Problem/Diagnosis</th>
<th>Date/Clinician</th>
<th>Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

2. **The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

3. **The patient has the following substance abuse problem(s) (if applicable):**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Date/Clinician</th>
<th>Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

4. **Please describe any special concerns (i.e., include abnormal lab results):**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Date/Clinician</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Section B: (completed by Primary Care Provider)**

1. **The patient is being treated for the following medical problem(s) and/or diagnoses: (list all)**

<table>
<thead>
<tr>
<th>Problem/Diagnosis</th>
<th>Date/Clinician</th>
<th>Referrer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. **The patient has the following BH (MH/SA) problem(s) (if applicable):**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Date/Clinician</th>
<th>Referrer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **Please describe any special concerns:**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Date/Clinician</th>
<th>Referrer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Primary Care Provider:** __________________________

**Primary Care Provider Signature:** __________________________

**Provider Name/Site Name:** __________________________

**Address:** __________________________

**Phone:** __________________________

**Fax:** __________________________

**Date this form completed:** __________________________

---

To make a referral to Care Management, please call the members' plan at:

- Boston Medical Center HealthNet Plan: (888) 444-5155
- Network Health: (888) 267-9986
- Fallon Community Health Plan: (888) 421-8861
- Neighborhood Health Plan: (800) 414-2620
- Primary Care Clinician Plan: (817) 790-8833
- Health New England: (817) 790-8833

(Updated 10/15/2019)
5. Massachusetts Department of Mental Health Two-Way Release of Information

Source: the Massachusetts Department of Mental Health

This form supports the exchange of information between the Department of Mental Health and other parties.
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: ________________________________ Other Name(s): ________________________________

Address: ____________________________ Phone: ________________________________

Social Security #: ____________________ Date of Birth: ________________________________

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: ____________________________ Attention: ____________________________ Phone: ________________________________

Street: ____________________________ City/Town: ____________________________ State: ________________________________

Zip: ________________________________

DMH Contact Information:

Name: ____________________________ Phone: ________________________________

Address: ________________________________

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g., Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & IAP(s), Physical Exam & Lab Reports, Progress Note(s):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Purpose for the authorization:
☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

☐ Coordinate care ☐ Facilitate billing

☐ Referral ☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify)

A copy of this authorization shall be considered as valid as the original.

DM Authorization for Release of Information - Two Way
HIPAA-P-4 (4/7/11)
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information: ____________________________

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event) _________________ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

X

Your signature or Personal Representative’s signature ____________________________ Date ____________________________

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) __________________________

Specially Authorized Releases of Information (please initial all that apply)

_____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

_____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

X

Your signature or Personal Representative’s signature ____________________________ Date ____________________________

INSTRUCTIONS:
1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.

DMH Authorization for Release of Information-Two Way
HIPPA-F-4 (4/7/11)
6. HIPAA/FERPA Exchange of Information

Source: Boston Public Schools

This form supports the exchange of information between schools in MA and health care providers. It has space for the school and providers to insert information about the child and the family or youth to indicate the timeframe for which the permission is valid.
<<District Name>>

HIPAA/FERPA Compliant Authorization for the Exchange of Educational And Health Information

| Patient/Student Name: __________________________ | Date of Birth: ____________ |
| School: ______________________________________ |
| Phone: __________________________ | Fax: _______________________ |
| School Nurse: __________________________ | Health Care Provider: ________ |

The purpose of this form is to facilitate communication between a school nurse and the child’s health care provider, for the purposes of optimizing the student’s learning experience. The school nurse may share information provided in this medical report with appropriate members of the educational team for use in meeting the student’s health and educational needs. This will be done on a “need to know” basis, in a confidential manner and may also include communication between health provider and school nurse to facilitate this process. Likewise, the medical provider may share information with the hospital or clinical team. Only those areas listed below will be shared.

<table>
<thead>
<tr>
<th>Health information from Health Care Provider to School (May attach additional management plans and ICHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue: __________________________</td>
</tr>
<tr>
<td>Information to be shared: __________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Information from the school to the Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue: __________________________</td>
</tr>
<tr>
<td>Information to be shared: __________________________</td>
</tr>
</tbody>
</table>

Authorization

This authorization is valid for one calendar year. It will expire on __________. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. By agreeing to allow communication between the Health care provider and designated school health I also understand that if I refuse to sign, such refusal will not interfere with my child’s ability to obtain health care.

Parent Signature __________________________ Date __________

Student Signature* __________________________ Date __________

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Massachusetts, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.
7. Early Childhood Developmental Interagency Referral Communication Form

Source: Olmsted County Communities Collaborating for Healthy Development team, Minnesota

This form can be adapted for use by Primary Care Providers to make referrals to Early Intervention (EI) services. It includes space for the EI provider to communicate back to the Primary Care Provider.
### Early Childhood Developmental Interagency Referral Communication Form

The information contained in this form is privileged and confidential information. If you are neither the intended recipient nor the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the content of this telecopied information is strictly prohibited. When sending this form, always attach the patient's current/consent form.

| Date: __________________________________________ |
| TO: (name, title) (phone) (fax) (address) (program/agency) |
| FROM: (name, title) (phone) (fax) (address) (program/agency) |

## CHILD INFORMATION

- **Child ID Number:**
- **Child's Name:**
- **DOB:**
- **Gender:**
- **Parent/Legal Guardian:**
- **Relationship:**
- **Primary Language:**
  - [ ] English
  - [ ] Spanish
  - [ ] Hmong
  - [ ] Somali
  - [ ] Other
- **Interpreter Needed:**
  - [ ] Yes
  - [ ] No
- **Home Address:**
- **Phone:**
- **Insurance:**
- **Known Pertinent Medical History:**

## REASON FOR REFERRAL (please check all that apply)

- [ ] Developmental Screening Tool Concern
- [ ] Mental Health Screening Tool Concern
- [ ] Medical/Health/Growth Concern
- [ ] Suspected developmental delay or concern
  - Motor/Physical
  - Cognitive
  - Vision
  - Hearing
  - Behavior/Adaptive
  - Speech/Language
  - Social/Emotional
  - Other
- Other Comments:
- Identified automatic qualification condition for early childhood services:
  - [ ] No
  - [ ] Yes (if yes, list ____________)

## OTHER REFERRALS

- [ ] Audiology:
- [ ] Social Worker:
- [ ] Home Care:
- [ ] Medical Specialist:
- [ ] Public Health Nursing:
- [ ] Mental Health:
- [ ] Private OT/PT/SLP:
- [ ] Help Me Grow/direct website:

## WHEN RETURNING THIS FORM, PLEASE INDICATE ATTACHED INFORMATION (Date: ____________)

- [ ] Consent form
- [ ] Developmental Screening, Assessment Information
- [ ] Mental Health Screening Assessment Information
- [ ] Individualized Education Plan/Individualized Family Service Plan
- [ ] Medical Reports, Diagnosis, Prescriptions
- [ ] Evaluation results/observations/progress report
- [ ] Summary of presenting problems
- [ ] Other

## RETURN COMMUNICATION (expected within 45 days B-3, 90 days 3-5)

- [ ] Evaluation in process
- [ ] Parent declined
- [ ] No response from parent
- [ ] Client not seen within 60 days
- [ ] Result of the assessment: Qualification
  - [ ] Yes
  - [ ] No
  - Date services started: ____________
- [ ] If no, ongoing monitoring? Yes
  - [ ] No
- [ ] Follow-up plan
- [ ] If yes, describe plan of action/services provided (i.e. frequency, duration, location, and type of service):
- Other relevant details/comments:
- Recommendations to referral source:

## RETURN TO:

- [ ] Olmsted County Public Health
- [ ] Help Me Grow
- [ ] Head Start/School Readiness
- [ ] Mayo Clinic
- [ ] Olmsted Medical Center
- [ ] Other Medical Provider

---

Appendix B: Forms and Policies
8. School Re-Entry After Hospitalization Form

Source: Massachusetts Department of Public Health School Unit and Children’s Behavioral Health Initiative

This form can be used for students who have been hospitalized for behavioral/mental health issues in order to facilitate a smooth and easy transition back to school.
# PUBLIC SCHOOLS

## BEHAVIORAL HEALTH

*Re-Entry to School Referral*

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
</tr>
</tbody>
</table>

**Anticipated Date of Return to School:**

**Primary contact person at school:**

**Secondary contact person:**

**Physician/therapist:**

**Phone:** Email:

---

**THIS SECTION IS ONLY TO BE FILLED OUT BY A PHYSICIAN/ THERAPIST**

**Functional Diagnosis:**

**DSM Diagnosis (optional):**

**Behavioral Health Concerns:**

**Maladaptive defenses:**

**Triggers:**

**Coping Strategies/ Interventions:**

**Relaxation/de-escalation techniques preferred /interventions:**

**Medication(s):**

**Date(s) Started:**

**Side Effects:**

6/4/2014 1

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Appendix B: Forms and Policies
Student/Family reply to questions about absence:

____________________________________________________________________

____________________________________________________________________

Considerations that may affect academic performance:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Physician/therapist signature ___________________________ Date ____________

I hereby authorize ___________________________ of ___________________________

Name __________________________________________________________________

Address/Organization

and ___________________________ of ___________________________

Name __________________________________________________________________

School Affiliation

to release information concerning ___________________________ to one another.

Name of Student

I also hereby release both parties from all liability and all claims pertaining to the

disclosure of this information.

Parent/Guardian Name (Print): ___________________________

Parent/Guardian Signature: ___________________________

Phone: ___________________________ Email: ___________________________

Public Schools person receiving this form: ___________________________

Signature

Forwarded to: ___________________________ Date: ___________________________

Name/Position

6/4/2014
9. Boston Public Schools Student Health Policy

Source: The Superintendent of Boston Public Schools

This is the 2011/12 policy on student health records, providing guidance to schools on rules that apply to confidentiality of information in the student record.
STUDENT HEALTH INFORMATION

State and Federal laws and regulations dealing with the confidentiality of student record information recognize that student health information is treated differently from other student record information. It should be noted that the Health Insurance Portability and Accountability Act, also known as HIPAA, does not apply to student records, with some exceptions not germane to this policy. See 65 Fed. Reg. 82805 (2000). School health personnel may have access to student health records, when such access is required in the performance of their official duties. 503 Code Mass. Regs. §23.07 (4)(h). Of course, a parent/guardian or in some circumstances the student himself or herself may consent to the release of student health record information to school personnel generally. In the absence of such informed written consent, however, the following standards should apply to a determination of which school officials may access what parts of a student’s health record. In the first instance, such determinations should be made by the building administrator, in consultation with the school-based nurse. If a disagreement arises, such concerns should be brought to the attention of the Director of Medical Services, Student Support Services, for resolution.

The following guidelines should be used:

1. **Routine medical information.** Such student health information should be disseminated only as is appropriate to meet the regular and effective educational mission of the school. Such information may include information contained in an IEP or 504 Plan, previously scheduled medical appointments, health-related incidents that may require or necessitate further reporting, or dispensation of medications. In all events, only the minimum necessary health record information should be disclosed. Thus, the type of medications dispensed would, absent more, not be disclosed in the above example. The fact that a medical appointment, necessitating early dismissal, is with a psychiatrist, would also not normally be disclosed as a matter of routine medical information.

   Routine medical information is information that is appropriate for certain staff to know in order to maximize the safety for children. For example, a child with diabetes needs to have teachers who are knowledgeable about the illness, in order for the child to have a safe learning environment. Low blood sugar can also affect the child’s ability to concentrate. In this circumstance it would be appropriate to notify all of the child’s teachers, individually. Health information should never be circulated by an all-staff memo.

2. **Medical information of limited dissemination.** Such student health information that is of a confidential nature and yet is of little educational benefit in the school. This is specific information that the Student Support Team needs to know to provide accommodations. When possible, all diagnoses, especially those related to mental health, should be expressed as a functional diagnosis. For example, it should be enough for the team to know that a child who is depressed is getting counseling. The details of the diagnosis or the causes of the depression are not relevant to the team’s provision of accommodations. The nurse provides the connection with the provider to interpret the medical information or when clarification is required.

3. **Highly sensitive information.** Such student health information of a highly sensitive nature that has no bearing on educational achievement and is of no educational use or consequence and in which a high expectation of privacy exists for students and/or parents or guardians. Such information may include: suicide attempts, treatment for drug or alcohol abuse, mental health diagnoses, family planning information, maternity/paternity tests or information, abortions, or HIV infection. This information is of two types: (1) no accommodations or safety issues and (2) highly sensitive
information. Medical diagnoses that have no relevance to a student’s performance do not need to be shared. For example, a child in therapy who is depressed but not suicidal and who is performing well in school, does not need to have this information shared with the school community. There are also highly sensitive medical situations that are protected by state regulations. These include HIV and a minor’s right to seek medical care for pregnancy, sexually transmitted diseases and substance abuse, without their parents’ consent. Any inclusion of this information in the educational record is a violation of the adolescent’s right to privacy. With HIV, the student/family can choose to disclose and can limit the individuals to disclose to. In some circumstances, such information is of such a private nature that even dissemination to a parent or guardian is prohibited. Questions in this regard should be directed to the Office of Legal Advisor. Such highly sensitive health information should, whenever possible, be segregated from the rest of a student’s health information to reduce the chance of inadvertent disclosure.

For more information about this circular, contact:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Alissa Ocasio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Office of Legal Advisor</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>26 Court Street, Boston, MA 02108</td>
</tr>
<tr>
<td>Phone:</td>
<td>617-635-9320</td>
</tr>
<tr>
<td>Fax:</td>
<td>617-635-9327</td>
</tr>
<tr>
<td>E-mail:</td>
<td><a href="mailto:aocasio@boston.k12.ma.us">aocasio@boston.k12.ma.us</a></td>
</tr>
</tbody>
</table>

Carol R. Johnson, Superintendent
10. Got Transition Policy

Source: the National Health Care Transition Center, a program of the Center for Medical Home Improvement. Used with permission from Got Transition, the National Health Care Transition Center which is supported by a cooperative agreement U39MC18176 HRSA/ US MCHB.

This policy document provides ideas and suggestions for primary care providers for creating and implementing a policy for transitioning youth from pediatric to adult primary care.
Sample Transition Policy
Six Core Elements of Health Care Transition 2.0

{Pediatric Practice Name} is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a "pediatric" model of care where parents make most decisions to an "adult" model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult's consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.
11. Holyoke Pediatric Associates Transition Policy

Source: Holyoke Pediatric Associates website

This document is an example of this practice’s stated policy on transitioning youth from pediatric to adult primary care.
POLICY ON TRANSITION TO ADULT HEALTH CARE

Holyoke Pediatric Associates (HPA) strives to serve as our patients’ Medical Home by partnering with patients and parents/guardians to deliver comprehensive, coordinated, family-centered care. We seek to respect both our patients’ legal rights to privacy and parents'/guardians’ concerns for the well-being of their child or young adult. We assist our patients to learn and practice the skills they will need as adults to become responsible for their own health and to manage their health care. We work with patients and families to assure a smooth transition to adult health care.

Patients 12-17 years old:
Beginning at age 12 years, at least part of a patient’s medical visit will generally be in private, and the parent/guardian will be asked to step out of the exam room. The patient or parent/guardian may ask for a nurse to be present in the exam room. Discussions of certain sensitive issues, such as sexual and mental health and substance use, will remain confidential and will not be shared with the parent/guardian unless the adolescent requests. Medical records documenting the corresponding portions of the medical exam and discussion also will be treated as confidential, to the extent required by law, and will be released to a parent/guardian or other person only with the patient’s written authorization.

For adolescent patients who have developmental disabilities or other special health needs, it may be necessary and appropriate to modify these policies to accommodate their needs. We welcome patients and parents/guardians to discuss special needs with us, so that we may plan reasonable accommodations together.

In addition, HPA will inform the parent/guardian of any life-threatening situation or behavior involving any patient younger than age 18 years, whether disclosed by the patient or becoming evident through medical examination. In this case, we will inform the patient that we will disclose or have disclosed this information to the parent/guardian.

Patients 18 years and older:
Patients 18 years and older are adults under the law.

HPA will respect these patients right to make their own health care decisions and manage their own health care, unless a court has determined that they are not able to do so and has appointed a legal guardian. Please provide us a copy of the court’s decree or equivalent documentation, if you have been appointed the legal guardian of your adult child so that we may conform to the terms of your guardianship.

HPA requires patients 18 years and older to make their own appointments at HPA, request their own referrals, and communicate about other care, billing, and insurance matters. We will gladly assist our patients of any age to understand and practice these skills. HPA cannot communicate with a parent or
other person on the patient’s behalf unless s/he is the legal guardian or authorized health care agent (proxy), or the patient has provided a written release.

HPA will respect the right of patients age 18 years and older to privacy regarding their health information and records. Providers will meet with and examine these patients privately unless the patient requests that the parent or other person be present. A young adult patient may authorize a parent or other person to receive medical information or records by signing a release of information. A release form is available at www.holyokepediatrics.com (in the left margin, click “Downloadable Forms”; then click “Authorization to release medical records”) or you may ask your HPA provider or Medical Records for a copy.

Understanding your insurer’s privacy policies:
Please be aware that young adults and children, who are insured under a parent’s family policy, might receive statements from the insurer at the parent’s address. HPA has no control over insurers’ procedures and is not responsible for any resulting disclosure of health information. Please contact your insurer about any questions regarding its privacy procedures and policies.

Transitioning from pediatric to adult health care: a partnership:
HPA serves patients from birth to 22 years of age. We welcome our young adult patients to continue in our care until they are 22 years old. By that age, patients should transition to an adult primary care provider (usually a doctor, nurse practitioner, or physician assistant practicing Family Medicine or Internal Medicine), as well as adult providers for any medical specialty care the patient may receive. We encourage you to start collecting information about adult health care providers well before age 22, usually around age 18-21 years. Remember to check with your insurer or ask the adult provider which insurances are accepted.

We are available to discuss health care transition with patients and families. We are committed to partnering with you throughout the process to assure a smooth transition.

Once you select you adult provider, please remember to sign a release promptly so we may send your medical records to this provider. You may use HPA’s release form at www.holyokepediatrics.com, the adult provider’s form, or other equivalent form. Please be aware that HPA disposes of medical records according to state law. This generally means that we retain records for seven years after the last date of service or until age 18 years, whichever is longer.

These policies follow generally accepted guidelines for pediatric practices, and federal and state law, including HIPAA (the federal Health Insurance Portability and Accountability Act) and Mass. General Laws (MGL). Please refer to: MGL c. 112 §12F and §125 Minors and Treatment for Pregnancy and Prenatal Care; MGL c. 111 §117 Minors and Treatment for Sexually Transmitted Diseases and HIV/AIDS; MGL c. 123 §10 Minors and Treatment for Mental Health; and MGL c. 112 §12E Minors and Treatment for Substance Abuse. This policy is not legal advice. Please consult a lawyer if you need legal advice.
12. Health Care Transition Checklist

Source: National Health Care Transition Center, a program of the Center for Medical Home Improvement. Used with permission from Got Transition, the National Health Care Transition Center which is supported by a cooperative agreement U39MC18176 HRSA/ US MCHB.

This checklist is designed to help Primary Care Providers track and monitor the implementation of the steps to transitioning a youth from pediatric to adult primary care.
# Health Care Transition Transfer of Care Checklist (Pediatric)

<table>
<thead>
<tr>
<th>&lt;Patient Name&gt;</th>
<th>&lt;Date of Birth&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date</td>
</tr>
</tbody>
</table>

- □ Transfer of care policy discussed with youth and family

- □ Transfer of care options discussed with youth and family
  - ○ Timing of transfer of primary care discussed with youth and family
  - ○ Option of using the family’s existing adult primary care provider(s)
  - ○ Review of the practice’s list of available adult primary care providers
  - ○ Options and timing for transfer of specialty care discussed

- □ Pediatric primary care practice confirms transfer with adult primary care practice
  - ○ For youth with special health care needs, personal communication between pediatric and adult primary care providers
  - ○ Date of transfer of care determined with mutual agreement

- □ Final youth readiness assessment completed

- □ Transfer of care package prepared or updated
  - ○ For all youth, include the following:
    - ▪ Cover or referral letter
    - ▪ Current portable medical summary
    - ▪ Most recent readiness assessment with action plan status
  - ▪ Final transition plan including
    - ▪ Name and contact information for pediatric primary care provider
    - ▪ Name and contact information for new adult primary care provider
    - ▪ Effective date for transfer

  - ○ For youth with special health care needs, include the following:
    - ▪ Cover or referral letter
    - ▪ Current portable medical summary
    - ▪ Condition-specific “fact sheet”
    - ▪ Current HCT action plan of pending and upcoming activities needing attention
    - ▪ Emergency care plan – what’s an emergency, what to do
<table>
<thead>
<tr>
<th>▪ Most recent readiness assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Relevant information, if appropriate, regarding guardianship, custodial arrangements, and powers of attorney</td>
</tr>
<tr>
<td>▪ Final transition plan including</td>
</tr>
<tr>
<td>• Name and contact information for pediatric primary care provider</td>
</tr>
<tr>
<td>• Name and contact information for new adult primary care provider</td>
</tr>
<tr>
<td>• Effective date for transfer</td>
</tr>
<tr>
<td>• Preferred means of interim communication and consultation between pediatric primary care team and adult primary care team identified and documented</td>
</tr>
</tbody>
</table>

| □ Transfer of care package communicated to adult primary care provider via best available means (mail, fax, email, electronic health information transfer) |
| □ Initial visit with new adult primary care provider scheduled |
| □ Follow-up communication with emerging adult (and family as appropriate) by pediatric primary care team regarding completion of transfer of care and level of satisfaction with result |
| □ Follow-up communication with new adult primary care team by pediatric primary care team regarding completion of transfer of care and level of satisfaction with results; identify any future plans/needs for on-going communication or consultation |