



Stone House Farm & Inn

Established 1813. Reimagined 2021.
2 Stonehouse Road Ellittsburg, PA 17024

Stone House Farm & Inn Referral Form Pre-Vocational Program

Date: ____/____/____

Referring Agency Name: _____

Referring Agency Phone Number: _____

Supports Coordinator Name: _____

Participant Information

Name of Individual: _____

Date of Birth: _____

Gender: _____

Address: _____

Phone Number: _____

Residence (check one): ☐ Group Home ☐ Resides with Family/Guardian/Caregiver

☐ Other: _____

Name of Parent/Guardian/Caregiver: _____

Address: _____

Phone Number: _____

What is the best time to contact Parent/Guardian/Care Taker?

How do you think this individual would enjoy attending Stone House Farm & Inn? What are the pre-vocational interests of this individual?

What day(s) is this individual interested in attending Stone House Farm & Inn?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Please provide as much information as possible with the referral (check all that apply and are attached to referral. Items with asterisk must be included before participant can start):

- | | | |
|--|--|--|
| ☐ Current Physical/TB Test* | ☐ Psychological/Psychiatric Evaluation(s) | ☐ List of Medication* |
| ☐ ISP* | ☐ Lifetime Medical History* | ☐ Other documents |
| ☐ BSP | ☐ Assessment(s) | |

Please fax completed forms to HEMPFIELD BEHAVIORAL HEALTH: 717-221-8006
or Mail to HEMPFIELD BEHAVIORAL HEALTH 2019 NORTH 2ND ST. HARRISBURG, PA 17102

For RTF Use Only

Pre-Admission Interview Date: ____/____/____ Employment Documents Given to Participant? ☐ YES ☐ NO

Date employment documents completed: ____/____/____ Received by: _____

Hempfield Behavioral Health
2019 North 2nd Street Harrisburg, PA 17102
717-221-8004 (phone) 717-221-8006 (fax)



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PARTICIPANT INFORMATION SHEET

Name:	
Admission Date:	
Date of Birth / Birth Place:	
Height:	
Weight:	
Eye Color:	
Hair Color:	
Race:	
Sex:	
Language:	
Identifying Marks:	
Allergies:	
Religious Affiliation:	

CURRENT MEDICATIONS

Medication Name	Dosage	Purpose

Likes/Strengths:

Dislikes/Triggers:

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PARTICIPANT PHOTO IDENTIFICATION

Participant Name:

Address:

Phone Number:

Date of Birth:

Allergies:

MCI:

Date of Picture:
(Attach photo)



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Participant Contact Information Form

Please Print

Participant Name:

Contact #1: Emergency Contact

Name:	
Phone Number:	
Relationship to Participant:	
Can this person consent for emergency medical treatment?	

Contact #2:

Name:	
Phone Number:	
Relationship to Participant:	
Can this person consent for emergency medical treatment?	

Contact #3:

Name:	
Phone Number:	
Relationship to Participant:	
Can this person consent for emergency medical treatment?	

Physician:

Name:	
Address:	
Phone Number:	



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Consent to Participate

Participant Name: _____ DOB: _____

I have been informed and provided a brochure about the services provided by the Stone House Farm at Hempfield Behavioral Health, and consent for the individual named above to participate in the Pre-Vocational Program. I have been made aware of the risks inherent in farm activities including livestock, farm work, outdoor exposure, and tools and machinery.

I am aware that I may terminate participation from Hempfield Behavioral Health (Stone House Farm & Inn) at anytime.

I am aware that Hempfield Behavioral Health agrees to maintain the confidentiality of any information regarding applicants, program participants, or their immediate families which may be obtained through applications, forms, interviews, test reports from public agencies, counselors, or any other sources. Without permission of the applicant, such information shall be divulged only as necessary for the purpose related to the performance or evaluation of the contract and the persons having responsibilities under the contract.

I am aware that Hempfield Behavioral Health also will provide client information to *Case Management Unit or County MHID Services* if that agency has made the referral for treatment. I understand that services for my participation will be billed to a third party.

I am aware that the above named individual in the process of emergency treatment by a health professional and information from Hempfield Behavioral Health is required for emergency treatment, necessary and limited related information to the emergency may be released without my consent.

I am aware that new or previously unreported incidents of sexual or physical abuse will be reported. In addition, any knowledge of potential danger to self or others may result in breach of confidentiality to the appropriate parties.

I have read this consent, had it explained to me, and understand its contents. I ☐ ACCEPT / ☐ REJECT a copy of this consent.

Participant Signature

Date

Parent/Guardian Signature and Relationship to Participant
(if Participant is unable to sign)

Date

Hempfield Behavioral Health Staff

Date

HBH Staff print name and credentials

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Pre-Vocational Client Rights and Responsibilities

Client Name: _____ DOB: _____

Participants, public, parents, and guardians will be treated with respect and dignity, and may expect all issues that affect their care to be handled in a confidential manner.

Additionally, clients have the right to:

- Choose a Provider of your choice
- Receive impartial access to necessary treatment and/or accommodations, regardless of race, color, religious creed, disability, ancestry, national origin, age, sex, or sources of payment for care
- Considerate, respectful treatment at all times
- Conduct interviews and be examined in surroundings designed to assure reasonable visual and auditory privacy
- Review communications and other records pertaining to their care, including the source of payment for treatment, and to have that information treated as confidential in accordance with the laws
- Obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis, and to participate in decision-making regarding their treatment planning
- Give informed consent before the start of any procedure or treatment
- Receive information in a medium that they can understand. If a client does not speak or understand the predominant language of the community, they are able to request funds for an interpreter
- Receive materials that describe important information about their care in a format that is easy to understand and easy to read
- A clear process for complaints and comments, with resolution in a timely manner
- Employees will be trained in clients rights during employee orientation
- Any complaints of discrimination may be filed with the U.S. Department of Health and Human Services Office of Civil Rights, The Department of Public Welfare Bureau of Equal Opportunity, EEOC, and/or The Pennsylvania Human Relations Commission:

Department of Public Welfare
Bureau of Equal Opportunity
223 Health & Welfare Building
Harrisburg, PA 17120

PA Human Relations Commission
Harrisburg Regional Office
333 Market St. 8th Fl
Harrisburg, PA 17011

U.S. Department of Health & Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

Equal Employment Opportunity Commission (EEOC)
Philadelphia District Office
801 Market St., Suite 100
Philadelphia, PA 19107-3126

As part of these rights, clients accept certain responsibilities which are outlined below:

- Respectful and courteous treatment of clinical and administrative staff
- Prompt and regular attendance at scheduled appointments

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- Full and complete disclosure of symptoms and changes in symptoms
- Active participation in evaluations and treatment sessions
- Prompt payment for services
- Presentation of accurate insurance and third party information
- Notice of changes in insurance status
- Completion of homework assignments
- Collection of information for treatment and service evaluation
- Use of the grievance procedure for conflict resolution
- Reporting dissatisfaction with any component of treatment and offering suggestions for improvement
- Disclosing other treatments and treatment providers

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

Participant Signature

Date

Parent/Guardian Signature and Relationship to Participant

Date

Hempfield Behavioral Health Staff

Date

HBH Staff print name and credentials



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Accident Waiver and Release of Liability

Participant Name: _____ DOB: _____

I assume all of the risks of participating in any and all activities at the Stone House Farm. I understand that there are certain risks associated with farming, working outside and working with live animals.

I verify that I am physically fit and have not been advised to not participate by a qualified medical professional. I verify that there are no health-related reasons or problems which preclude my participation in activities at the Stone House Farm.

I release Hempfield Behavioral Health and its representatives from all liability, to me or my representative for all claims, demands, losses or damages, related to participation in activities at the Stone House Farm.

I have read this consent, had it explained to me, and understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

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Authorization to Photograph

Name of Participant: _____ Participant DOB: _____

I consent to let Hempfield Behavioral Health photograph the above mentioned participant.

Hempfield Behavioral Health would like to photograph you for educational and marketing purposes. These images may appear in our printed brochure, publications, website or Facebook.

I agree that Hempfield Behavioral Health has complete ownership of these pictures and may use them for any purpose consistent with the mission of HBH. These uses may include: illustrations, publications, advertisements, and promotional or educational materials. I acknowledge that I will not receive any compensation.

I understand that I am NOT required to be photographed and I am under no obligation to be photographed. I understand that my access to services will NOT be affected by my decision to not be photographed. I may revoke this consent at any time by informing the Program Director and/or contacting the President, Dr. Howard S. Rosen at 717-221-8004. I may contact Dr. Howard S. Rosen, Ph.D. 717-221-8004 at any time with questions or concerns.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

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Authorization to Videotape

Participant Name: _____ Participant DOB: _____

I consent to let Hempfield Behavioral Health videotape for educational and marketing purposes. These images may appear on our website or Facebook or in educational or marketing presentations.

I agree that Hempfield Behavioral Health has complete ownership of these images and may use them for any purpose consistent with the mission of HBH. These uses may include: illustrations, publications, advertisements, and promotional or educational materials. I acknowledge that I will not receive any compensation.

I understand that I am NOT required to be videotaped and I am under no obligation to be recorded. I understand that my access to services will NOT be affected by my decision to not be videotaped. I may revoke this consent at any time by informing the therapist and/or contacting the President, Dr. Howard S. Rosen at 717-221-8004.

I may contact Dr. Howard S. Rosen, Ph.D. 717-221-8004 at any time with questions or concerns.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

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TRANSPORTATION AUTHORIZATION

Participant Name: _____ Participant DOB: _____

I authorize Hempfield Behavioral Health staff to transport the individual listed above in the HBH vans or staff vehicles. I understand that all riders must wear seat belts.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

Participant Signature

Date

Parent/Guardian Signature and Relationship to Participant
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PERMISSION FOR MEDICAL SERVICES

Participant Name: _____ Participant DOB: _____

I hereby give permission to Hempfield Behavioral Health to secure all routine medical services or emergency first aid for the above mentioned individual.

I understand that Hempfield Behavioral Health will make every reasonable effort to contact me whenever a condition arises that requires other than routine medical services. However, in the event that an emergency exists and I cannot be reached within a reasonable time, I give permission to Hempfield Behavioral Health to secure any and all medical services to meet the medical emergency.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

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PERMISSION FOR OUTINGS

Participant Name: _____ Participant DOB: _____

I give permission for the staff of Hempfield Behavioral Health to take the above mentioned participant on day outings during program hours.

I, _____, do not give permission for the staff of Hempfield Behavioral Health to take the above mentioned participant on day outings during program hours.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

Participant Signature

Date

Parent/Guardian Signature and Relationship to Participant
(if Participant is unable to sign)

Date

Hempfield Behavioral Health Staff

Date

HBH Staff print name and credentials



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Permission for Exchange of Information

I, _____, hereby authorize Hempfield Behavioral Health to release/receive information contained in the record of _____ DOB: _____.

NAME OF AGENCY / PERSON: Group Home: _____

ADDRESS: _____

THE FOLLOWING INFORMATION MAY BE RELEASED / RECEIVED:

- | | | |
|---|--|--|
| ☐ Family History | ☐ Neurological Reports | ☐ Case Management Intake / Assessment |
| ☐ Treatment / Service Plan | ☐ Physical Exam / Immunizations | ☐ Vocational Skills Assessment |
| ☐ Progress Reports | ☐ Attendance Data | ☐ Behavior Plan |
| ☐ Discharge Summaries | ☐ Individual Education Plan | ☐ Achievement Tests |
| ☐ Individual Support Plan | ☐ Medical Reports | ☐ Psychological / Psychiatric Evals |
| ☐ Other: | | |

For the purpose of: _____

Effective Date(s) From: _____ To: _____

I fully understand the nature of this consent and that this authorization shall remain in effect from the date of my signature for a period not exceeding 1 year. However, I may revoke this authorization at any time by written, dated communication to the Executive Director or designee. A photo static copy of this authorization will be considered valid, and all information will be held in strict confidence. I understand that the policy of Hempfield Behavioral Health is to release only that information about a present or former recipient of services, which, in judgment of its personnel, is considered essential to the purpose for which the authorization is requested. It is also a policy of Hempfield Behavioral Health **to release only information generated by them and not other agencies or institutions.**

I ACCEPT ☐ / REJECT ☐ A COPY of this release.

Participant Signature

Date

Parent/Legal Guardian and Relationship (if Participant is unable to sign)

Date

Witness Signature and Title

Date

Witness Print Name and Credentials

To be completed if the recipient of services is physically unable to provide a signature, but has indicated verbally or behaviorally that he/she consents to the release.

We affirm that _____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect from this date to _____ (1 year hence). However, this may be revoked by verbal or behavioral communication to the Executive Director or his/her designee.

Witness Signature and Relationship

Date



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Permission for Exchange of Information

I, _____, hereby authorize Hempfield Behavioral Health to release/receive information contained in the record of _____ DOB: _____.

NAME OF AGENCY / PERSON: MHIDD: _____

ADDRESS: _____

THE FOLLOWING INFORMATION MAY BE RELEASED / RECEIVED:

- | | | |
|---|--|--|
| ☐ Family History | ☐ Neurological Reports | ☐ Case Management Intake / Assessment |
| ☐ Treatment / Service Plan | ☐ Physical Exam / Immunizations | ☐ Vocational Skills Assessment |
| ☐ Progress Reports | ☐ Attendance Data | ☐ Behavior Plan |
| ☐ Discharge Summaries | ☐ Individual Education Plan | ☐ Achievement Tests |
| ☐ Individual Support Plan | ☐ Medical Reports | ☐ Psychological / Psychiatric Evals |
| ☐ Other: | | |

For the purpose of: _____

Effective Date(s) From: _____ To: _____

I fully understand the nature of this consent and that this authorization shall remain in effect from the date of my signature for a period not exceeding 1 year. However, I may revoke this authorization at any time by written, dated communication to the Executive Director or designee. A photo static copy of this authorization will be considered valid, and all information will be held in strict confidence. I understand that the policy of Hempfield Behavioral Health is to release only that information about a present or former recipient of services, which, in judgment of its personnel, is considered essential to the purpose for which the authorization is requested. It is also a policy of Hempfield Behavioral Health **to release only information generated by them and not other agencies or institutions.**

I ACCEPT ☐ / REJECT ☐ A COPY of this release.

Participant Signature

Date

Parent/Legal Guardian and Relationship (if Participant is unable to sign)

Date

Witness Signature and Title

Date

Witness Print Name and Credentials

To be completed if the recipient of services is physically unable to provide a signature, but has indicated verbally or behaviorally that he/she consents to the release.

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Witness Signature and Relationship

Date



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ANNUAL PHYSICAL EXAMINATION FORM

Name: _____

Date of Exam: _____

Address: _____

SSN: _____

DOB: _____

DIAGNOSES/ SIGNIFICANT HEALTH CONDITIONS:

CURRENT MEDICATIONS (attach a second page if needed):

Medication Name	Strength	Dose	Frequency	Diagnosis	Prescribing Physician

Allergies/Sensitivities: _____

Contraindicated Medications: _____

IMMUNIZATIONS:

Tetanus/Diphtheria (every 10 years): ____/____/____

Hepatitis B: ____/____/____

Flu shot: ____/____/____

Pneumovax: ____/____/____

Other (specify): _____

TB SCREENING: (every 2 years by Mantoux method, if positive initial chest x-ray should be done)

DATE Given _____ Date read _____ Results _____

Chest X-ray (date) _____ Results _____

OTHER MEDICAL/ LAB/ DIANOSTIC TESTS:

GYN EXAM W/pap _____ Date _____ Results: _____

(Women over age 18)

Mammogram: _____ Date _____ Results: _____

(Every 2 year-women ages 40-49, yearly for women 50 and over)

Prostate Exam: _____ Date _____ Results: _____

(Digital method-males 40 and over)

Hemoccult _____ Date _____ Results: _____

Urinalysis _____ Date _____ Results: _____

CBC/ Differential _____ Date _____ Results: _____

Hepatitis B Screening _____ Date _____ Results: _____

PSA _____ Date _____ Results: _____

Other (specify) _____

Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure: ____/____ Pulse: ____/____ Respirations: ____/____ Temp: ____/____ height: ____/____ Weight: ____/____

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EVALUATION OF SYSTEMS

System Name	Normal Findings?	Comments/ Description
Eyes	☐ Yes ☐ No	
Ears	☐ Yes ☐ No	
Nose	☐ Yes ☐ No	
Mouth/ Throat	☐ Yes ☐ No	
Head/ Face/ Neck	☐ Yes ☐ No	
Breasts	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Cardiovascular	☐ Yes ☐ No	
Extremities	☐ Yes ☐ No	
Abdomen	☐ Yes ☐ No	
Gastrointestinal	☐ Yes ☐ No	
Endocrine	☐ Yes ☐ No	
Musculoskeletal	☐ Yes ☐ No	
Integumentary	☐ Yes ☐ No	
Renal/ Urinary	☐ Yes ☐ No	
Reproductive	☐ Yes ☐ No	
Lymphatic	☐ Yes ☐ No	
Nervous System	☐ Yes ☐ No	
VISION SCREENING	☐ Yes ☐ No	Is further evaluation recommended by specialist? ☐ Yes ☐ No
HEARING SCREENING	☐ Yes ☐ No	Is further evaluation recommended by specialist? ☐ Yes ☐ No

Additional Comment:

Lifetime medical history summary reviewed? ☐Yes ☐No

Medication added, changed, or deleted (from this appointment): _____

Special medication considerations or side effects: _____

Recommendations for health maintenance: (including need for lab work at reg. intervals, exercise, hygiene, weight control, etc.)

Recommended diet and special instructions: _____

Information pertinent to diagnosis and treatment in case of emergency:

Free of Communicable Diseases? ☐Yes ☐No (if no, list specific precautions to prevent the spread of disease to others)

Limitations or restrictions for activities (including work day, lifting, standing, and bending) ☐No ☐Yes (specify):

Change in health status from previous year? ☐No ☐Yes (specify): _____

Continuation of same level of care (e.g., ICF, CLA, Other) ☐Yes ☐No (specify): _____

Specialty consults recommended? ☐No ☐Yes (specify): _____

Name of Physician (please print)

Physician's Signature

Date

Physician Address: _____ Physician Phone: _____

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LIFETIME MEDICAL HISTORY

DATE:

Patient Name: _____

Address: _____

Phone: _____

DOB: ____/____/____

Primary Physician

Name: _____

Address: _____

Phone: _____

OVERVIEW:

DEVELOPMENTAL INFORMATION:

FAMILY/SOCIAL HISTORY:

HOSPITALIZATIONS & SURGERIES:

DIET AND NUTRITION:

MEDICAL HISTORY

Vision:

Hearing:

LIFETIME MEDICAL HISTORY

Respiratory:

Cardiovascular:

Digestive:

Nervous System:

Musculoskeletal:

Genito-Urinary:

Endocrine/Lymphatic:

Integumentary:

Dental:

Psychiatric/Behavioral:

Other:

ALLERGIES/PRECAUTIONS:

LIFETIME MEDICAL HISTORY

IMMUNIZATIONS:

Measles, Mumps, Rebella (MMR)	
Polio	
Hepatitis B Surface Antibody	
Hepatitis B Vaccination Series	
Diptheria/Tetanus	
Pneumonia (Pneumovax)	
Influenza	
Manatoux	
Other	
Other	

CURRENT HEALTH STATUS: