BOBBY BENSON CENTER
56-660 Kamehameha Highway, Kahuku, HI 96731
Phone (808) 293-7555 Fax (808) 293-7196
bobbybenson.org

SPECIAL INSTRUCTIONS FOR COMPLETING: *PRESCRIPTIONS & MEDICAL HISTORY FORM*

PART 1 MUST BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN.

Please include any significant medical history (asthma, allergies, limitations, disabilities, psychiatric conditions, chronic illnesses, recent injuries or symptoms, etc). List existing or needed appointments, medical devices, or supplies. If there is any condition requiring medication, have the Client's prescribing Provider(s) complete Parts 2 & 3, as needed.

PART 2 AND PART 3 MUST BE COMPLETED AND SIGNED BY THE PRESCRIBING PROVIDER(S).

The appropriately licensed Provider (MD, DO, PA, APRN, NP) who actually prescribes the medication must complete and initial/sign. All medications that will be brought to BBC must be listed, including oral and alternately administered medications (e.g. topical lotions, suppositories), inhalers, EpiPens, and any over-the-counter medications.

***IMPORTANT*: Provide a PRESCRIPTION and/or the actual medication/inhaler/EpiPen/other device with a PRESCRIPTION LABEL attached to box/bottle/tube/inhaler/device**.

BBC must have its Medical Director and/or Psychiatrist approve written authentication by the prescribing Provider(s), as indicated above, prior to administering medication. This includes having a prescription label.

This documentation must be submitted one week prior to intake. Failure to do so may result in delayed medical care. Thank you.

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Client Name: **DOB:** **DOA: ___ / ___ / _____**

PRESCRIPTIONS & MEDICAL HISTORY FORM, 1 of 2

(*See SPECIAL INSTRUCTIONS for completion of this form*)

Part 1: To be completed by Parent/Guardian

I, the undersigned, authorize the Bobby Benson Center (BBC) staff to store all medication prescribed by an appropriately licensed provider for the client listed above. I authorize the BBC staff to oversee that the medication prescribed by the client's provider be taken correctly as directed by the provider's instruction(s) listed below and any other medication that may be prescribed by a provider during the client's stay at BBC. I also request and authorize the BBC staff, the nurse, and the prescribing provider listed below to be able to release information to each other that is deemed pertinent to the client's medical condition.

Diagnoses: _____

Allergies: _____ **Asthma** ☐ Yes ☐ No

Medical History: _____

Upcoming Appointments: _____

Please indicate any assistive devices the client <u>currently</u> uses for activities of daily living:

- ❑Hearing aids ❑ TDD (telecommunication device for the Deaf)
- ❑Eye glasses ❑ Contact lenses ❑ Braille materials
- ❑ Wheelchair ❑ Crutches ❑ **None**
- ❑Other: _____

Are there any assistive devices that <u>need to be obtained</u> for use?

- ❑Hearing aids ❑ TDD (telecommunication device for the Deaf)
- ❑Eye glasses ❑ Contact lenses ❑ Braille materials
- ❑ Wheelchair ❑ Crutches ❑ **None**
- ❑Other: _____

Who is responsible and/or already working on obtaining any devices listed above:

_____ x_____

Print Parent/Legal Guardian Name (Relationship) Signature of Parent/Legal Guardian Date

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Client Name: **DOB:** **DOA: __/__/____**

PRESCRIPTIONS & MEDICAL HISTORY FORM, 2 of 2

Part 2: To be completed by Provider Prescribing Psychiatric Medication

Diagnoses: _____ **Allergies:** _____ **Asthma** ☐ Yes ☐ No

Medical History: _____

Upcoming Appointments: _____

Current Medication or Medical Device/Equipment	Dosage/Frequency/ Administration Instructions	Reason Why Prescribed (Diagnosis)	Side Effects Experienced by Client	Provider Initials	BBC USE ONLY: Brought to BBC Intake
					☐
					☐
					☐

_____ x_____

Print Provider Name Signature of Provider Date

Part 3: To be completed by Provider Prescribing NON-Psychiatric Medication

Diagnoses: _____ **Allergies:** _____ **Asthma** ☐ Yes ☐ No

Medical History: _____

Upcoming Appointments: _____

Current Medication or Medical Device/Equipment	Dosage/Frequency/ Administration Instructions	Reason Why Prescribed (Diagnosis)	Side Effects Experienced by Client	Provider Initials	BBC USE ONLY: Brought to BBC Intake
					☐
					☐
					☐

_____ x_____

Print Provider Name Signature of Provider Date

Part 4. BBC Nurse Verification (BBC USE ONLY):

_____ x_____

Print BBC Nurse Name **Signature of BBC Nurse** **Date**

Comments: