MDT PSYCHIATRIC EVALUATIONS

Referral Request Form

Wyoming Department of Health

WHAT IS AN "MDT PSYCHIATRIC EVALUATION"? A one-time evaluation performed at the request of a child's Multidisciplinary Team (MDT) for the purpose of aiding mental/behavioral health assessment and/or treatment planning. This MDT psychiatric evaluation can be used as the tool to inform the team of a broad range of treatment planning issues including level of care, diagnosis, medication strategies and appropriate psycho-social supports. It also can serve as the physician order for admission to a psychiatric residential treatment facility (PRTF). This is a program of Wyoming's medical school and Wyoming Department of Health.

TO REFER A CHILD FOR AN EVALUATION Verify access to telemedicine equipment. Complete this form & send required records.

phone 206-987-7932 **fax** 206-985-3195 **email** mdtconsult@seattlechildrens.org **web** wyomingmdteval.org

REFERRAL

Today's Date: ☐

Question(s) you want the psychiatrist to address (in 1-2 sentences):

Purpose of Evaluation:	☐ MEDICATION ISSUE	☐ DIAGNOSIS ISSUE	☐ PLACEMENT ISSUE
Required Records based on Purpose of Evaluation (if applicable):	Current medication list Past medication trials	Current medication list Past psychological evaluation Past psychiatric evaluation Testing reports	Current medication list Admission assessment DFS placement and/or social history

Required Consents for all Consultations:

- Completed MDT Psychiatric Consultation Referral Form
- Signed MDT Consult Description/Consent
- Signed Ambulatory Consents for Care Form
- Signed Consent to Telemedicine Consultation
- Release of information from current providers (therapist, primary care doctor, psychiatrist)

Helpful Records for all Consultations:

- Most Recent MDT Meeting Summary
- DFS Placement and/or Social History
- Current IEP or 504 Plan & Supporting Psycho-educational Testing
- Assessments of Intellectual Disability (Adaptive Functioning and IQ Testing)
- Residential Treatment Discharge Summaries

Please be advised, evaluations are based on information made available to the consultant on or before the appointment date. Information submitted after the appointment date will most likely not be included in the report.

REFERRING INDIVIDUAL

Your Name: ☐ ☐ DFS ☐ Guardian Ad Litem

Location: ☐

Email: ☐ Phone: ☐ Fax: ☐

MDT PSYCHIATRIC EVALUATIONS

CHILD/YOUTH

Legal Name: Nickname: DOB: Gender: M F

Medicaid #: Previous psychiatric eval performed by us? No Yes, date:

Special health concerns or active medical issues that affect placement? No Yes, please explain:

Who is the legal guardian of the child (name/relationship)?

Reason for DFS/GAL involvement? CHINS Abuse/neglect Delinquency

Other, please explain:

Where is child currently living?

How long in this placement?

CAREGIVERS

Caregiver Name:

Relationship: custodial parent foster parent non-custodial parent kinship placement

other

Phone:

CURRENT TREATING PROVIDERS

Primary Care Physician

Name: Phone: Fax:

Mental Health Provider or Therapist

Name: Phone: Fax:

Community Psychiatrist

Name: Phone: Fax:

Input from current providers is very helpful. Written statements from these individuals is encouraged—please fax or email them to us. Also, please make sure a release of information is included for each of these individuals so we can communicate with them as needed.

APPOINTMENT

Appointment Location:

Location Contact

Name: Phone:

Email:

People to be present at appointment (name/relationship):

MDT Psychiatric Evaluation: Description and Consent

A "MDT Psychiatric Evaluation" is a one-time consultation provided at the request of a child's Multi Disciplinary Team (MDT) or Medicaid Utilization Reviewer for the purpose of aiding mental/behavioral health assessment and/or treatment planning. The consultation is performed by a child psychiatrist at Seattle Children's Hospital under a contract with the Wyoming Department of Health. Referrals can be made for a variety of reasons, but typically are due to a concern that behavioral problems, psychological issues or psychiatric symptoms are impacting functioning, safety or placement needs. **There will be no financial charges to parents and/or caregivers for a MDT Psychiatric Evaluation.**

Outcomes of an MDT Evaluation may include, but are not limited to, providing an opinion about whether a mental health problem (like depression, anxiety, or ADHD) is impacting current behavior, providing education about treatment options and implications of a current diagnosis; recommending appropriate treatment for identified psychiatric and behavioral issues; reviewing the appropriateness of current medications; and discussing treatment planning/placement considerations for mental health problems and unsafe behaviors. Recommendation(s) will vary depending on the focus of the consult but may include suggestions about medications; further assessment of relevant medical issues; recommendations about appropriate levels of supervision and behavioral support; appropriate family and community interventions; indicated psychological treatments; strategies to identify and address academic and behavioral needs; and placement suggestions. *MDT Psychiatric Evaluations will NOT formally diagnose learning disorders, perform IQ or other standardized psychological testing, recommend who should have custody, forensically investigate sexual abuse, prescribe levels of supervision within a facility, or directly mandate a placement.*

Information reflected in the report and subsequent recommendations are limited to information provided at the time of the consultation and may not reflect all relevant/pertinent information. The resultant report should be used in conjunction with other pertinent information collected by the MDT in an effort to provide the best possible care. Documentation provided in support of this consultation may be reviewed at the discretion of the consultant. Helpful past documentation includes previous psychiatric or psychological assessments, inpatient/ residential treatment discharge summaries, recent IEPs, recent primary care notes, psychiatric or therapy progress notes.

CONSENT for MDT Psychiatric Evaluation

I have read the above information and agree to participate. I understand that information provided for purpose of this evaluation will be made available to the MDT members and a judge assigned to the case, and may be used in further treatment planning. Because this is a consultation requested by a third-party, **information shared during this process and the assessment resulting from this consultation are NOT subject to usual doctor-patient confidentiality in that the completed report will go to the requestor and through them to the associated MDT.** This report and/or information contained herein may be provided to other involved medical/legal entities and/or other care providers at the discretion of the requesting party.

Patient's Name: _____

Legal Guardian signature: _____ *Date*: _____

Patient signature (if 18 years or older): _____ *Date*: _____

AMBULATORY

CONSENT FOR CARE AND FINANCIAL TERMS AND CONDITIONS

1. CONSENT FOR CARE

I, patient/parent/authorized representative, give permission for examinations, diagnostic procedures, medical treatment and other hospital services. Such services will be performed or prescribed by or at the direction of the attending doctors/dentists and their designees as judged necessary for the medical care of the patient. These may include x-ray examinations, lab tests (including, for females age 12 or older, a pregnancy test), sedation, and the use of local anesthesia (whether performed at Seattle Children's Hospital (Children's) or at other facilities). I understand that Children's is a teaching hospital and that doctors in training and other health care students may join in or observe the care of the patient. I give permission for my/the patient's body fluids (blood, urine, etc.), tissues and organs removed during the course of treatment to be used for scientific and/or research purposes. This biological material will be unmarked to protect my/the patient's identity and used only after diagnostic and/or therapeutic uses have been completed.

2. FINANCIAL TERMS AND CONDITIONS

I agree:

- To assign to Seattle Children's Hospital (Children's) and Children's University Medical Group, University of Washington Physicians (CUMG/UWP) all insurance benefits payable for services rendered.
- To pay Children's and CUMG/UWP in a timely manner for any uncovered services or balance remaining after insurance benefits.
- To authorize Seattle Children's Hospital (Children's) to act as my representative in any appeal of an adverse determination concerning my insurance coverage for health care services.
- To notify Children's and CUMG/UWP of changes to my insurance coverage and/or address and phone number.
- That Children's and CUMG/UWP may charge me reasonable interest, late charges, costs and/or reasonable attorney fees should my account become overdue.
- That any lawsuit for collection of my account will be brought in King County, Washington.

I understand that:

- Many Seattle Children's Hospital clinics are licensed as part of the hospital. If I am seen at one of these clinics, I will receive a separate charge or billing for the hospital facility services which may result in higher out of pocket expenses.
- Seattle Children's Hospital and CUMG/UWP send separate bills. CUMG/UWP bills professional fees on behalf of many of the physicians.
- If I am eligible for financial assistance, my bill may be reduced or waived.
- If I dispute a claim, or a claim involves a third party, Children's will not negotiate with the third party for me. It is my responsibility to pay the bill on time, settle the dispute, and/or collect from the third party.

For Medicare Beneficiaries:

I request payment of authorized benefits, when applicable, be made on my/the patient's behalf. I authorize any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits for related services.

3. PHOTOGRAPHS/VISUAL IMAGES/AUDIO RECORDINGS

I authorize Seattle Children's Hospital to take and reproduce photographs, video and audio recordings in connection with my/the patient's diagnosis, care and treatment, and other operational purposes such as medical education.

SIGNATURES			
	SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT	RELATIONSHIP TO PATIENT	TODAYS DATE ____ / ____ / ____ (month / day / year) Time: ____
	WITNESS	2ND Telephone Witness	A language interpreter was used to explain this consent ____ Name of Interpreter ☐ by phone ☐ by video

Notice of Privacy Practices

Children's Notice of Privacy Practices describes how health information about you/your child may be used and disclosed, and how you can get access to that information. **Please initial below if you were offered a copy of this notice.**

Initialed by patient's legal representative:	or: **Initialed by Children's staff**
_____ Yes, I received a copy of Children's Notice of Privacy Practices.	_____ N/A (Per Epic, Notice was offered at previous visit)
_____ No, I do not want a copy of Children's Notice of Privacy Practices.	_____ N/A (Consent obtained by phone)

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PATIENT LABEL

AMBULATORY CARE
CONSENT FOR CARE AND FINANCIAL TERMS AND CONDITIONS

AUTHORIZATION TO OBTAIN/RELEASE PATIENT HEALTH INFORMATION (PAL)

PATIENT NAME: _____

DATE OF BIRTH: _____

SEATTLE CHILDREN'S MED REC # _____

I authorize Seattle Children's Hospital to (check all that apply) ☐ **Obtain** information ☐ **Release** information ☐ **Mutual exchange** of information

Organization/Individual: _____ Attn: _____

Address _____

City, State, Zip _____

Phone #: (_____)_____ Fax#: (_____)_____

☐ Please send the information requested in an electric format (e.g. CD)

Information to be Obtained:

Dates of service for records requested: from _____ to _____

- ☐ OT/PT/Speech reports
- ☐ Child welfare/CPS records
- ☐ Juvenile court/probation records
- ☐ Chemical dependency records
- ☐ Psychosocial assessment
- ☐ Neuropsychological evaluation
- ☐ Developmental Evaluation
- ☐ Verbal exchange of information
- ☐ Other _____
- ☐ Outpatient medical notes
- ☐ Birth/neonatal records
- ☐ Growth charts
- ☐ Laboratory/test reports
- ☐ Education records
- ☐ Individualized Education Plan
- ☐ Inpatient medical notes
- ☐ Psychiatric treatment/crisis plan
- ☐ Outpatient psychiatric evaluation
- ☐ Psychological testing/assessment (including subtests scores)
- ☐ Inpatient psychiatric discharge summary
- ☐ Psychological/Psycho-educational Assessment records
- ☐ Psychotherapy records/treatment plan

Information to be Released:

Dates of service for records requested: from _____ to _____

- ☐ Discharge summary
- ☐ Outpatient psychiatric evaluation
- ☐ Psychological testing/assessment
- ☐ Psychiatric treatment/crisis plan
- ☐ Psychiatric treatment/termination summary
- ☐ Inpatient psychiatric discharge summary
- ☐ Psychological/Psychoeducational Assessment records *(including subtest scores)*
- ☐ Psychotherapy records/treatment plan
- ☐ Written and/or phone confirmation of outpatient psychiatry appointments sent to patients residence
- ☐ Inpatient Psychiatry Education Dept Discharge Summary
- ☐ Developmental Evaluation
- ☐ Psychosocial assessment
- ☐ Neuropsychological evaluation
- ☐ Inpatient medical notes
- ☐ Medication management notes
- ☐ OT/PT/Speech records
- ☐ Verbal exchange of information
- ☐ Chemical dependency records
- ☐ Specific records as requested by parent/patient
- ☐ Other _____

For the Purpose of:

☐ Participation in ☐ outpatient ☐ inpatient ☐ medical ☐ psychiatric ☐ neuropsychological ☐ developmental evaluation/treatment
☐ Coordination of care between multiple providers ☐ Transfer of care to a new provider
☐ Other (please specify): _____

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below unless another date or event is entered here _____
Exception: If patient information is to be released to an employer or financial institution, this authorization is valid for only 90 days from date signed.
I specifically authorize Seattle Children's Hospital to release health information regarding mental health/illness and alcohol/drug abuse.

_____ _____ _____
Signature of patient (☐ 13+ years) Date Time

_____ _____ _____
Signature of parent/legal representative Relationship to patient Date Time

Release Requiring Specific Consent- I specifically authorize Seattle Children's Hospital to release health information checked below:
☐ Sexually Transmitted Diseases (incl. HIV/AIDS) ☐ Reproductive Care

_____ _____ _____
Signature of Patient/Legal Representative Printed Name Date & Time

Minors - A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

Requested Records to be Sent to:

☐ **Seattle**- Partnership Access Line (PAL) at Seattle Children's PO Box 5371, W3636, Seattle WA 98105, Fax 206-985-3195
☐ Multi Disciplinary Team (MDT) Evaluations at Seattle Children's- PO Box 5371, W3636, Seattle WA 98105, Fax 206-985-3195
☐ **Spokane**- Partnership Access Line (PAL) at Seattle Children's - Paulsen Center 421, W. Riverside Ste 612, Spokane WA 99201, Fax 206-985-3109
☐ Drug Utilization Review at Seattle Children's - Paulsen Center 421, W. Riverside Ste 612, Spokane WA 99201, Fax 206-985-3109

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AUTHORIZATION TO OBTAIN/RELEASE PATIENT HEALTH INFORMATION (PAL)

PATIENT LABEL

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with the following pediatric specialist:

_____

_____

1) **Purpose and Benefits.** The purpose of this project is to use telemedicine to enable patients living in rural and/or underserved areas to get medical care by specialists without the inconvenience and expense of traveling to a city.

2) **Nature of Telemedicine Consultation:** During the telemedicine consultation:
   a) Details of you and/or your child's medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
   b) Physical examination of you or your child may take place.
   c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
   d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3) **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. The telemedicine studio at Seattle Children's is in a private room. All existing confidentiality protections under federal and Washington State law apply to information disclosed during this telemedicine consultation.

5) **Risks and Consequences.** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Following the telemedicine consultation, your physician may recommend a visit to Seattle Children's for further evaluation.

6) **Rights.** You may withhold or withdraw consent to the telemedicine consultation at any time without effecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the specialist in person if you travel to his or her location.

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

SIGNATURES

SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT	RELATIONSHIP TO PATIENT	TODAYS DATE ____ / ____ / ____ Time: ____ (month / day / year)
SIGNATURE OF ADDITIONAL FINANCIAL GUARANTOR	RELATIONSHIP TO PATIENT	
WITNESS	2ND Telephone Witness	A language interpreter was used to explain this consent _____ Name of Interpreter

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SEATTLE, WASHINGTON 98105

CONSENT FOR TELEMEDICINE CONSULTATION

PATIENT LABEL HERE

Joint Notice of Privacy Practices

of Seattle Children's Hospital and Certain Other Providers

Notice effective 7/10/2013

We are required by law to:

- Protect the privacy of your information.
- Provide this notice about our privacy practices.
- Follow the privacy practices described in this notice.
- Notify you if your patient health information has been compromised.

Summary

While you are receiving care at Seattle Children's Hospital, doctors, nurses and others create and receive information about you, your health history and treatment. This is known as "your patient health information."

Most patients of Seattle Children's Hospital are children. When we talk about "you" or "your" in this notice, we are talking about the patient. It doesn't matter if the patient is a child or an adult. When we talk about "disclosures to you," we mean disclosures to the patient, the patient's legal representative, or a person allowed to receive information about the patient. We are responsible for protecting your health information.

You have certain rights. You may:

- See and receive copies of your patient health information.
- Ask for a change or addition to your patient health information.
- Ask for a list of ways your patient health information has been disclosed or shared outside Children's.
- Ask us to contact you another way.
- Ask that we limit the use of your patient health information.
- Make a complaint about the privacy of your patient health information.

You may also:

- Ask us not to give your name and health status to callers and visitors during your hospital stay.
- Ask us not to share information with family members.

Following certain rules, we may use and share your patient health information:

- To perform treatment, healthcare operations or to get payment.
- To teach and train staff and students.
- To do research approved by an Institutional Review Board.
- As required or allowed by law, or with your written authorization.

The law provides extra protection for these types of patient health information:

- Sexually transmitted disease information (including HIV/AIDS)
- Drug and alcohol abuse treatment records
- Mental health records

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please read it carefully.

This notice describes your rights and our responsibility to protect the privacy of your patient health information. It tells you about laws that give you protection for this information. Children's privacy practices apply to all Children's patients. This notice explains how your patient health information is used, and how and when it may be disclosed. It also tells you that we may change this notice and how you can find out about the changes.

Healthcare providers covered by this notice

- Seattle Children's Hospital
- Seattle Cancer Care Alliance
- UW Medicine, including University of Washington Physicians and other University organizations
- UW School of Dentistry
- Children's University Medical Group
- Other providers when they use Children's facilities

Healthcare providers covered by this notice

Children's works with other organizations and providers for healthcare services and other healthcare operations. This notice gives you information about the use and disclosure of your patient health information by these providers: Seattle Children's Hospital; Seattle Cancer Care Alliance; UW Medicine, which includes University of Washington Physicians and other University organizations; the UW School of Dentistry; and Children's University Medical Group. In addition, other providers agree to follow this notice when they deliver care or other services at Children's facilities.

Children's

Children's includes organizations that work together and share patient health information. When it's appropriate, Children's shares your information to give clinical care services, get payment for these services and perform other joint healthcare operations. Children's is composed of its medical staff, healthcare providers, employees, contract staff, residents, students and volunteers at Children's facilities. These facilities include:

- Seattle Children's Hospital
- Odessa Brown Children's Clinic
- Children's Bellevue Clinic and Surgery Center
- Children's Outpatient Clinics in Washington, Alaska and Montana. See the current list at www.seattlechildrens.org/clinics-programs/
- Children's Autism Center
- Children's Consulting Nurses
- Children's Home Care Services
- Children's Orthotics & Prosthetics
- Children's Prenatal Diagnosis and Treatment Program
- Garfield/NOVA Teen Clinic

Your patient health information rights

You have rights for the use and disclosure of your patient health information. You may:

Review and receive copies.

You have the right to look at or ask for a copy of your health record unless there are other protections under the law. You will need to make your request in writing. You may tell us if you would like to receive a paper copy or an electronic copy of the record. In some cases, you may be charged copying fees.

Your patient health information rights

- Review and receive copies
- Request a change or addition to your record
- Know about disclosures
- Request restricted use
- Receive confidential communications
- Make complaints

Request a change or addition to your record.

If you think information in your record is not correct or that important information is missing, you have the right to ask that we correct or add information. You must make this request in writing. Your request must give a reason for the change or addition. We are not required to grant your request, but we will add a copy of your request to the record.

Know about disclosures.

You have the right to receive a list of disclosures of your patient health information that Children's has made as required by law. This list does not include disclosures related to treatment, payment or healthcare operations or disclosures you have authorized. The first request you make for your information in a 12-month period is free of charge. You will be charged a processing fee for any other requests made within the same 12 months.

Request restricted use.

You have the right to ask Children's not to let your insurance company know about an item or service if you pay in full before we send a bill. Call Business Services at 206-987-3333 for more information. You also have the right to ask us in writing to restrict certain other uses and disclosures of your patient health information. We are not required to grant these requests, but we will honor any requests we do grant.

Receive confidential communications.

You have the right to ask us to tell you about health matters in a certain way or at a certain location. You must request this in writing. For example, you may ask us to contact you only at work or only by mail. Your request must tell us how or where you want to be contacted. We will let you know if we will grant your request.

Make complaints.

If you are concerned that we may have violated your privacy, or you disagree with a decision we have made about access to your records, you may file a complaint with Children's Privacy Office. Children's will not retaliate against you for filing a privacy complaint.

How we use your patient health information

This notice applies to patient health information created at or received by Children's providers. It identifies you and relates to your past, present or future physical or mental condition. It also has to do with the care you receive, and past, present or future payment for the care. This information is often found in your health record. The main reasons we use your patient health information are to:

- Communicate among health professionals who help with your care.
- Provide a legal record for the care you receive.
- Send bills so that we can get payment for the care you receive.
- Let you or a third-party payer make sure your bill matches with the services you received.

Children's may also give information to:

- Teach health professionals.
- Support public health activities.

- Monitor, measure and improve the care we give and the results we achieve.
- Provide medical research data.
- Do planning for the organization.

Understanding your record and how your patient health information is used helps you to:

- Make sure the record is accurate.
- Learn who, what, when, where and why others may access your patient health information.
- Make an informed decision when you give permission to share information with others.

How we can use and disclose your information without your authorization

Here are some examples of how we may use and share your patient health information without your authorization:

Treatment

We may use and share your patient health information to give or arrange care for you. For example:

- Your doctors use your information to decide if they should order specific diagnostic tests, therapies and medications.
- Nurses, technicians or other employees may need to know about and talk about your information. They may use it to provide treatment and to measure your response to treatment.
- We may share your information with your other care providers in the community.

Payment

We use and share your patient health information to get payment for healthcare services. For example, if you are covered by health insurance and we bill the insurance directly, we include information that identifies you, your diagnosis, procedures you received and supplies we used.

Healthcare operations

We may use and share your patient health information to schedule, check and improve healthcare services. We may also use it to measure the performance of staff caring for you and others. For example, supervising doctors may look at your patient record to measure quality of care.

Training

We may use and share your information to teach and train staff and students. For example, teaching doctors may look at patient health information with medical students.

Research

We may use and share your information for research. An Institutional Review Board (IRB) looks at each request to use or disclose information for research. An IRB looks at projects for safety and to make sure the rights of people who take part in the research are protected.

How we can use and disclose your information without your authorization

- Treatment
- Payment
- Healthcare operations
- Training
- Research
- Contacting you
- Fundraising
- Joint activities
- Business Associates
- Other uses and disclosures

Your patient health information may be used or shared for some research without your consent. For example, we might:

- Look at medical charts to see if people who wear bicycle helmets get fewer head injuries.
- Use patient health information to decide if we have enough patients for a cancer research study.
- Include patient health information in a research database.

In these cases, an IRB first decides if we have a good reason to use your information without your permission. The IRB also makes sure we take steps to limit the use of your information. The IRB may let researchers record information that identifies you, if it is important for the research.

In all other cases, we must get your permission to use or share your information before you take part in a research project. We may share patient health information about you with researchers at other institutions with your permission, or if an IRB approves it.

Contacting you

Your patient health information may be used to contact you. For example, we may call you or send you a letter to:

- Remind you about appointments.
- Provide test results.
- Let you know about treatment options.
- Let you know about health education events or services.

Fundraising

Children's may give patient health information like your name, address, phone number and dates of service to our Foundation and Guild Association. This information may be used to contact you about fundraising for Children's healthcare mission. If you are contacted for fundraising, you may request not to be contacted again. We must honor your request.

Joint activities

Providers may use or share your patient health information for joint activities with other individuals or organizations to:

- Provide clinical care services.
- Make sure we receive payment for clinical care services.
- Perform other joint healthcare operations.

For example, we may share your patient health information for joint activities with doctor groups and other doctors who are part of Children's medical staff.

Business Associates

Some of our services are provided by Business Associates. We may share your patient health information with them so they can do their jobs. Some examples of associates we use are management consultants, auditors, transcription services and information storage services. We require associates to sign contracts to protect your information.

Other uses and disclosures

We may share your patient health information to make healthcare services better, protect patient safety and public health, make sure we follow government and accreditation standards, and when otherwise allowed by law. For example, we may give information to:

- Healthcare oversight agencies for auditing or licensure
- Public health authorities about infectious diseases and vital records
- Government agencies when we suspect abuse or neglect
- Appropriate individuals to avoid a serious threat to health or safety, or to prevent serious harm to others
- Organizations that specialize in organ donation activities
- Law enforcement when required or allowed by law
- Courts when ordered, or by lawful subpoena
- The FDA
- Coroners, medical examiners and funeral directors
- Government officials as required for specific government functions like national security
- Public or private organizations (such as FEMA or the American Red Cross) that are authorized by law to help in disaster relief efforts

Uses and disclosures that must have your authorization

Other than the uses and disclosures listed in this notice, we will not use or share your patient health information without your written authorization. If you give us written authorization, you may cancel that authorization at any time unless:

- We require disclosure to get payment for services you have already received.
- We have already relied on the authorization.
- The law prohibits you from cancelling it.

In some situations, the law provides special protections for specific kinds of patient health information like drug and alcohol treatment records and mental health records. When required by law, we will contact you to get written authorization to use or disclose that information.

We must have your written authorization before using or disclosing your patient health information for marketing purposes or before selling it.

Times when you can ask us not to share your patient health information

- Hospital Inpatient Directory
- Disclosure to family, friends or others

Times when you can ask us not to share your patient health information

Hospital Inpatient Directory

If you are admitted to the hospital, we list you in a directory. This information only includes name, location in the hospital and general health condition (for example, "satisfactory," "serious," "critical"). Unless you tell us not to, we may provide this information to visitors or callers who ask for you by name. You can choose to put your family's religion on the admission form. If you do, we may give your name and location to clergy of your religion.

Disclosure to family, friends or others

Unless you tell us not to, your healthcare providers will use their professional judgment to give appropriate patient health information to a family member, friend or other person you name.

Other providers covered by this notice

Seattle Cancer Care Alliance (SCCA)

SCCA operates together with Children's, UW Medicine and Fred Hutchinson Cancer Research Center to provide both inpatient and outpatient cancer care. Patient health information is shared among these organizations when appropriate for treatment, payment and certain joint healthcare operations. This notice applies to SCCA's use and disclosure of your information for treatment SCCA provides at Children's. For a description of SCCA's privacy practices, which apply to all other SCCA activities, please refer to its Notice of Privacy Practices.

UW Medicine and UW School of Dentistry (UW SOD)

UW Medicine and UW SOD, through faculty doctors, dentists and other healthcare providers, provide or take part in clinical care services at Children's. Patient health information is shared among Children's and these organizations when appropriate for treatment, payment and certain joint healthcare operations such as peer review and quality improvement activities, accreditation activities and evaluation of trainees.

Children's University Medical Group (CUMG)

Faculty doctors of the University of Washington School of Medicine who practice with CUMG, a nonprofit healthcare provider, provide or take part in clinical care services at Children's. Patient health information is shared between Children's and CUMG when appropriate for treatment, payment and certain joint healthcare operations. Examples include conducting quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; developing compliance programs; and engaging in business planning, development and management and general administrative activities.

To exercise your privacy rights or to make a complaint, you may contact:

Children's Privacy Office
Mailstop OC.6.820
PO Box 5371
Seattle, WA 98145-5005

206-987-1200
1-866-987-2000, ext. 7-1200 (Toll-free)

privacy.questions@seattlechildrens.org

If you have a complaint, you may also contact:

Office for Civil Rights, Region X
U.S. Department of Health and Human Services
Mailstop RX-11
2201 Sixth Avenue
Seattle, WA 98121-1831

206-615-2290
206-615-2296 (TTY)
206-615-2297 (Fax)
1-800-362-1710 (Toll-free)
1-800-537-7697 (TTY)

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Notice of Privacy Practices

Notice of Privacy Practices

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

4800 Sand Point Way NE
PO Box 5371
Seattle, WA 98145-5005

206-987-2000 (Voice)
206-987-2280 (TTY)
1-866-987-2000 (Toll-free for business use only)
1-866-583-1527 (Family Interpreting Line)

www.seattlechildrens.org

We reserve the right to change the privacy practices in this notice and the right to make these changes for both your existing and future patient health information. We post the current notice at Children's facilities. You can request a copy at any Children's facility, from the Family Resource Center at the hospital or from our Web site (www.seattlechildrens.org).

Children's offers interpreter services for Deaf, hard of hearing or non-English speaking patients, family members and legal representatives free of charge. Children's will make this information available in alternate formats upon request. Call the Family Resource Center at 206-987-2201.

PI397
Rev. 7/13

Our Mission

We believe all children have unique needs and should grow up without illness or injury. With the support of the community and through our spirit of inquiry, we will prevent, treat and eliminate pediatric disease.

Free Interpreter Services

- In the hospital, ask your child's nurse.
- From outside the hospital, call the toll-free Family Interpreting Line 1-866-583-1527. Tell the interpreter the name or extension you need.
- For Deaf and hard of hearing callers: 206-987-2280 (TTY)

Seattle Children's provides healthcare for the special needs of children regardless of race, sex, creed, ethnicity or disability. Financial assistance for medically necessary services is based on family income and hospital resources and is provided to children under age 21 whose primary residence is in Washington, Alaska, Montana or Idaho.

Children's offers interpreter services for Deaf, hard of hearing or non-English speaking patients, family members and legal representatives free of charge. Children's will make this information available in alternate formats upon request. Call the Family Resource Center at 206-987-2201.

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PI090
Rev. 1/13

Rights and Responsibilities

of Patients and Families

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Rights and Responsibilities of Patients and Families

Seattle Children's Hospital promises to provide high-quality, family-centered care. Patients and families all are members of the care team. This brochure explains what you and your family can expect as members of the care team. It also gives you ways to voice your comments and concerns.

To show respect we will:

- Tell you who we are and explain our role in your child's care.
- Provide considerate care that protects your dignity and respects your cultural, social and spiritual values.
- Honor you and your child's personal privacy.
- Keep your child's medical records, discussions about their care and family information private.
- Take actions to relieve your child's pain using medicines and other comfort measures.*
- Provide safe care in a secure setting free from abuse, with access to protective services.*
- Keep your child free from restraints and seclusion except when needed and as allowed by law.

To support your child and family we will:

- Let you stay with your child during most medical treatments, if you choose.
- Provide a place for one adult family member to spend the night near your child.
- Help you meet other families who have had experiences like yours, if you choose.
- Offer pastoral care and other spiritual services.*
- Explain how you can give us your comments, share concerns or file a complaint.
- Review concerns promptly and resolve them when we can.

Important telephone numbers

Main hospital number	206-987-2000 (Voice) 206-987-2280 (TTY)
Billing	
Hospital bills/ financial assistance	206-987-5770 (Patient Accounts) 866-987-5770 (Toll-free)
Physician bills	206-987-8455 (Children's University Medical Group) 888-675-2864 (Toll-free)
Child abuse and neglect	206-987-2194
Comments or concerns	206-987-2550 (Patient and Family Relations)
Cultural and diversity services	206-987-3676
Deaf and hard-of-hearing services	206-987-5010 (Voice) 206-987-2280 (TTY)
Disability access	206-987-2260
Ethical concerns or consult	206-987-2000 (Ask operator for ethics consultant)
Health information	206-987-2201 (Family Resource Center) 206-987-2098 (Library and Information Commons)
Medical records copy	206-987-2173
Privacy	206-987-1200 privacy.questions@seattlechildrens.org
Religious or spiritual services	206-987-2000 (Ask operator for chaplain)
Security concerns	206-987-2030
Social Work	206-987-2167

- Advance Directives
- Counseling
- Support groups

- Call Patient and Family Relations at 206-987-2550 or 1-866-987-2000 (toll-free). Or, if you'd like to speak to someone in your own language, call the Family Telephone Interpreting Line at 1-866-583-1527 and ask the interpreter to connect you with 206-987-2550.
- Go to www.seattlechildrens.org/familyfeedback.
- Send an e-mail to family.feedback@seattlechildrens.org.
- Fill out a comment card, which you'll find at our entrances, and give it to a staff member.
- Write to: Seattle Children's Hospital
  Patient and Family Relations
  P.O. Box 5371, Mailstop RB.7.420
  Seattle, WA 98105-0371

By calling or writing Patient and Family Relations about your grievance, you can expect acknowledgement of your concern within 7 days. If additional time is needed, we will give you an estimated date for a final response.

You may also file a complaint directly with the Washington State Department of Health:

- By calling 1-800-633-6828 or 360-236-4700
- By writing: HSQA Complaint Intake
  P.O. Box 47857
  Olympia, WA 98504-7857
- By e-mail: HSQAComplaintIntake@doh.wa.gov

If we cannot resolve your concerns, you may contact The Joint Commission, Office of Quality Monitoring. You can register your complaint by:

- Phone: 1-800-994-6610
- E-mail: complaint@jointcommission.org
- Web site: www.jointcommission.org

- Welcome visitors of your choice. This could include a spouse, domestic partner (including a same-sex domestic partner), family member or friend. You can refuse these visitors anytime.

To help make information clear we will:

- Involve you in your child's plan of care and explain treatment outcomes in a way that you can understand.
- Provide interpreters for Deaf, hard-of-hearing or non-English speaking patients, family members and legal representatives free of charge. We also will make information available in other formats if you request it.
- Communicate with your child's primary care provider. This includes notifying the provider promptly of your child's hospital admission and other important changes in therapy.
- Teach you about the care your child will need before they go home or are transferred.
- Talk with you about people and places in your community that can help you with your child's healthcare needs.
- Provide your child's medical records for review and explain how to request a copy of them.
- Give you our "Notice of Privacy Practices," which explains how we use patient information and about the rights you have about your child's health information.*
- Give you a copy of "About Your Hospital Bill," which answers some of the most common questions about bills.
- Explain how you can apply for Children's financial assistance even if you have insurance.*
- For our patients 18 years and older, we will provide you written information about advance directives when you are admitted.*

You have choices about your child's care. You may:

- Receive information about treatment options and their risks so you can make informed choices about care, including refusing care as allowed by law.

- Choose to help with your child's care, treatment and services when it is safe to do so.
- Choose to have a chaperone, such as a medical assistant, present during physical exams and sensitive procedures.
- Choose or refuse to take part in a research project presented to you. Your decision will not affect the quality of care we give your child.
- Request a change in healthcare providers.
- Request an ethics consult when there are confusing or difficult care issues.*

* There is information on this topic in the Family Resource Center (206-987-2201). Some of it also is available online at www.seattlechildrens.org.

Parents and Family Members: Your responsibilities as partners in patient care:

- Share correct and complete information about your child's health and medical history.
- Ask questions and take an active part in decisions about your child's plan of care.
- Tell us right away if you have concerns about your child's safety or feel their care is at risk.
- Talk about pain-relief options and help make a pain-relief plan for your child.
- Learn about your child's healthcare needs. Follow the treatment plan at home or tell us if you are not able to follow the plan.
- Keep appointments or let us know if you cannot come.
- Respect the privacy and the rights of other children, families and staff at Children's.
- Follow Children's rules, such as those for visitors, smoking, alcohol, illegal drugs and weapons.
- Follow your health insurance rules for referrals and so that your bill is paid.

Patients: As a patient at Children's, you can expect to:

- Be called by your name.
- Have friendly, caring staff who treat you with respect, take the time to listen and value your opinions and choices.
- Have prompt treatment and feel safe and comfortable.
- Be given medicine or other comfort measures for pain relief, if needed.
- Have privacy during exams, treatments and meetings.
- Have information about your illness and your health questions kept private.
- Be involved in decisions about your care and have staff answer your questions truthfully.
- Have your family and friends around to comfort you and help take care of you when they are able and it is safe.
- Have your visitation rights supported. We may need to restrict or limit your visitors for medical reasons. However, we will not restrict, limit or deny visitors based on race, color, national origin, religion, sex, gender identity, sexual orientation or disability.
- Be provided with an interpreter or assistive device if you need one.
- Have time to rest, sleep, study and play.
- Learn what you need to know and do when you go home.

As a patient at Children's, your responsibility is to try your best to treat other patients, families and staff with respect and to follow the hospital safety rules.

Comments or Concerns

We want to provide the best care for you and your family. Your suggestions help us improve our services. Here are the ways you can give us your comments:

- Speak with your child's nurse. If your nurse is not able to help, ask to speak with a charge nurse or the manager of that area.