

CONSENT FOR PSYCHIATRIC SERVICES

University of Iowa Student Health

Please PRINT (except signatures) and provide complete information in each section.

This completed form must be scanned into EPIC

Patient Name _____ Birth Date _____ UI ID _____ Date _____

I, the undersigned, authorize treatment by the Student Health (SH) psychiatrists and other licensed or certified behavioral health clinicians. I understand:

- Treatment may include prescription and monitoring of psychotropic medications, lab monitoring, referral, psychoeducation, sleep hygiene, brief psychotherapy.
- Medications may be recommended for my symptoms. If so, my provider and I will discuss and decide together. With any medication, there are risks of side effects which we will discuss.
- The practice of psychiatry is not an exact science and I acknowledge SH makes no guarantees to me as to the results of tests, treatments or any other services rendered.
- I have the right to terminate treatment at any time.
- I have the right to ask questions.

I am aware I have the right to confidential treatment of disclosures and records and an opportunity to approve or refuse their release as described in the [University of Iowa Health Care Privacy Notice](#). I am aware there are exceptions to confidentiality as described in the Privacy Notice and these include but are not limited to:

- The SH staff work as a team. My psychiatrist and psychiatric nurse may consult with another SH psychiatrist or family practice provider to provide the best possible care.
- If I pose a threat of harm to myself and/or others, SH will take steps necessary to comply with applicable laws.

I will promptly arrive for my appointments and if I need to cancel, call 24 hours prior to my appointment time. This allows SH time to use the appointment slot for others. If I do not cancel at least 24 hours prior to my appointment, I may be charged a fee.

I understand my continued treatment at SH is contingent on enrollment at University of Iowa. Prior to graduation or leaving University of Iowa I will work with my treatment team to transfer my care if indicated.

Signature (Patient or person authorized to consent for patient) _____ Date _____

Printed Name (Patient or person authorized to consent for patient) _____ Date _____

**IF THE PATIENT IS A MINOR A PARENT/GUARDIAN AUTHORIZATION/CONSENT TO TREAT A MINOR FORM MUST ALSO BE COMPLETED. **

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University of Iowa Student Health PSYCHIATRY HEALTH HISTORY FORM

Patient ID Label

Patient Legal Name _____

Preferred Name _____ Date of Birth _____

Preferred Pronouns _____ University ID Number _____

<input type="checkbox"/> Undergraduate Student	Major _____	Expected year of graduation _____
<input type="checkbox"/> Graduate Student		Current GPA _____

Did anyone refer you today?

University Counseling Service

Student Health Provider

Self

Other: _____

Briefly describe the problem that prompted you to make the appointment:

PAST MEDICAL HISTORY

History of surgeries

History of medical problems

Current medical conditions

Current Medications - Name of medication / dose / how often taken

Allergies - Name of allergy / reaction experienced (include food/environmental allergies)

PAST PSYCHIATRIC HISTORY

History of counseling / therapy (Indicate when, where, and name of counselor)

Previous trials of psychiatric medications

Medication name	Dates Taken	Maximum dose	Side effects	Was it helpful?

Previous psychiatric hospitalization(s) (Indicate when and where)

History of past suicide attempts

No Yes - details: _____

BIOLOGICAL FAMILY HISTORY

Adopted

Family History Unknown

No Known Problems	Depression	Anxiety	Bipolar	Schizophrenia	Substance Abuse	Thyroid Disease	Suicide	OCD	ADHD	Other - please list
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Relationship	Living?	Age	No Known Problems	Depression	Anxiety	Bipolar	Schizophrenia	Substance Abuse	Thyroid Disease	Suicide	OCD	ADHD	Other - please list	Comment
Mother	Yes No													
Father	Yes No													
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No													
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No													
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No													
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No													
Maternal Grandmother	Yes No													
Maternal Grandfather	Yes No													
Paternal Grandmother	Yes No													
Paternal Grandfather	Yes No													
Extended family	Yes No													
	Yes No													
	Yes No													
	Yes No													

SOCIAL HISTORY

Please describe your primary parental figures.

Parent name:	Parent name:
Relation	
Education	
Occupation	

Parent's marital status?

Married

Never Married

Divorced (when?)

Separated (when?)

Siblings: Brothers	Name	Age

Siblings: Sisters	Name	Age

Describe past/current family difficulties:

What town(s) did you grow up in?

SOCIAL HISTORY (continued)

Education	
High School	
City, State	
Year Graduated	
GPA/Rank	
Previous college/community college?	

ACT Scores (or SAT scores)
Composite
English
Math
Reading
Science

Legal: Have you ever been arrested and/or convicted of a crime?
<input type="checkbox"/> No <input type="checkbox"/> Yes :

Relationship Status
<input type="checkbox"/> Single
<input type="checkbox"/> Dating
<input type="checkbox"/> Married
<input type="checkbox"/> Divorced
<input type="checkbox"/> Partnered
<input type="checkbox"/> Other:

Living Situation
<input type="checkbox"/> On Campus
<input type="checkbox"/> Off Campus
<input type="checkbox"/> With Family:
Roommates? <input type="checkbox"/> No <input type="checkbox"/> Yes :
How many? <input type="checkbox"/> <input type="checkbox"/>

Exercise
How often?
What form?

Nicotine use				
	Never	In the past, not now	Currently using	How frequently and for how long?
Smokeless (chew, snuff)				
Vaporized (e-cigs, vape)				
Cigarettes				
Hookah				
Cigars				

Any additional information you would like us to know?

Signature

Printed name

Date