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 is risk 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. If I need to cancel, I will 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.

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

☐ Undergraduate Student	Major	Expected year of graduation
☐ 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

Relationship	Living?	Age	No Known Problems	Depression	Anxiety	Bipolar	Schitzophrenia	Substance Abuse	Thyroid Disease	Suicide	OCD	ADHD	Other - please list	Comment
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sibling ☐Sister ☐Brother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sibling ☐Sister ☐Brother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sibling ☐Sister ☐Brother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sibling ☐Sister ☐Brother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Extended family			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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?
☐No ☐Yes :

Relationship Status
☐Single
☐Dating
☐Married
☐Divorced
☐Partnered
☐Other:

Living Situation	
☐On Campus	
☐Off Campus	
☐With Family:	
Roommates?	☐No ☐Yes :
How many?	

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 _____

CLICK HERE to SUBMIT to Student Health upon completion