BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

TO: Potential BIP Student

SUBJECT: INTAKE FORMS

Enclosed you will find forms to be completed as a part of Brunswick Interagency Program Admissions process.

Please read and complete the forms to the best of your knowledge. If you have any questions or concerns, please feel free to contact us. Once you have completed the forms, please call to set-up an appointment and tour our facility.

We are also requesting documentation to verify that the Intellectual/Developmental Disability occurred prior to age 22. This can be a Psychological or an IEP from their previous school, Medical Insurance (Medicaid, Medicare or other insurance), the students State ID, Social Security Card and if the student is not their own legal guardian please bring the original court documentation. Copies will be made during your scheduled appointment.

Transportation may be requested and will be submitted to BTS (Brunswick Transit System) after the Admissions process is completed.

Thank you and we look forward to seeing you and your student.

Brunswick Interagency Program
(910) 755-7364
www.brunswickcc.edu

BRUNSWICK
COMMUNITY COLLEGE

LEANN CECIL, BA/QP
Director, Brunswick Interagency Program

PO Box 30
Supply, NC 28462
www.brunswickcc.edu

Direct | 910.755.7381
Main | 910.755.7300
Fax | 910.755.7493
cecill@brunswickcc.edu

BRUNSWICK COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

SCREENING AND FINANCIAL EVALUATION FORM

DEMOGRAPHIC INFORMATION

Name: ______________________________ Client # ____________

Address: ____ Marital Status ____________

City: ______________________ State: ____________ Zip Code: ____________

Maiden Name: ________________ Nickname: ______________________________

Date of Birth: __________________ Home # ________________ Cell #________________

Social Security # _________________________

Guardian/Responsible Person: Name ____________________________ Address ____________________

****

INSURANCE INFORMATION (Please provide a copy of all Insurance Cards)

Primary Insurance# ________________ Name: _______________ Group# _____________

Policy # ____________________ Employer: ______________________________________

Policy Holder Name: ________________________________ Relationship: _______________

Social Security # _________________________________ Date of Birth: _________________

Secondary Insurance# ______________________ Name: ________________ Group# ________

Policy #: ________________________________ Employer: __________________________

Policy Holder Name: ____________________________________ Relationship: _____________

Social Security # ___________________________ Date of Birth: _______________________

INCOME SOURCE

Source	Employer	Yearly Income
____________________	______________________________	________________
____________________	______________________________	________________

Total # of Dependents ______ Total Family Income ________________

Verification: ____

PLEASE NOTIFY THE STAFF WHEN THERE IS A CHANGE IN YOUR FINANCIAL STATUS.

Acknowledgement: By my signature, I certify that these statements are true to the best of my knowledge and I agree to pay the fee for services as determined above.

_________________________________ ____________________

Guardian/Client/Student Date

_________________________________ ____________________

Interviewer Date

BRUNSWICK
COMMUNITY COLLEGE

Brunswick Interagency Program

HEALTH ASSESSMENT

Name: ________________________ School: Brunswick Interagency Program/BCC

Address: ________________________ City: ______________ State: __________

Date of Birth: ___/___/_____ Age: ____ Phone# ________________________

Name of Insurance: ____________________ ID# ________________________

Name of Insurance: ____________________ ID# ________________________

Allergies (if any): ____

Current Medications/ Dosage:

____

____

Please check all that apply

Yes	No		Yes	No	
___	___	Heart Disease	___	___	Diabetes
___	___	Seizures/Epilepsy	___	___	Asthma
___	___	Hearing Loss	___	___	Heat Stroke
___	___	Serious Head Injury/Concussion	___	___	Special Diet
___	___	Major Surgery/Serious Illness	___	___	Free Bleeder
___	___	Visual Impaired/Wears glasses	___	___	Chest Pains
___	___	Bone/Joint Pain	___	___	Tobacco Use
___	___	Emotional/Psychiatric Behavior	___	___	Sickle Cell Disorder

Other Medical Conditions:: ____

____

____

Blood Pressure _____/_____ Weight ______________ Height ____________

Date of Physical: ________________________

Physician's Name: ________________________

Address: ________________________ City: ____________________ State: ______

Phone # ____________________

BRUNSWICK
COMMUNITY COLLEGE

Written Consent Permission Form to Release Confidential Information

If a student wishes Brunswick Community College to share his/her educational records with his/her parents/guardians this form must be signed.

Please print clearly, except where signatures are required. Unreadable names will be disregarded.

I, ______________________________ ID# ______________________
(Print student full name) (Social Security# or BCC ID#)

Date Signed: ______________________ Expiration Date: ________________

authorize representatives of Brunswick Community College to release any and all information contained in all BCC educational records as indicated below.

I understand that all Brunswick Community College educational records may/will be shared with my parent(s) or legal guardian(s) via the designated Brunswick Community College representative(s) and the Office of Student Services.

My parent(s)/legal guardian(s) are:

Name: ____

Relationship: ____
(Print parent/guardian full name)

Name: ____

Relationship: ____
(Print parent/guardian full name)

Student Signature: ____________________________________

Updated 6/2022

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

CONSENT FOR EMERGENCY MEDICAL TREATMENT

NAME: ______________________________ DOB: ________________________________

MID#: ______________________________ RECORD# ____________________________

In case of emergency, accident or illness, I give my consent for the staff to provide and/or obtain emergency medical treatment.

Physician's Name: __________________________ Phone # ____________________________

DIAGNOSIS: ____

ALLERGIES (if any): ____

CURRENT MEDICIATIONS: (if any)

____ ____________________________________

____ ____________________________________

____ ____________________________________

Emergency Contact Name: __________________________ Relationship: ___________________

Phone Number: Cell: ______________________________ Work: __________________________

I fully understand the above statement that has been read and explained to me by the member of the BIP staff.

____ ______________________________

Client | Date

(If under 18 Parent/Guardian must sign)

____ ______________________________

Parent/Guardian Signature | Date

____ ______________________________

Witness | Date

Updated 6/2022

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
50 College Road, NE
Bolivia, North Carolina 28422

Consent for Release of Information

CLIENT:

DATE:

REOCRD NUMBER:

I hereby authorize Dr. ____ to release specified information in my patient records to: BRUNSWICK INTERAGENCY PROGRAM.

____

____

____

____

For Specific: Establishing eligibility and updating information for the records.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information, I hereby acknowledged that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

______________________ Client

______________________ Witness

OR

______________________ Legal Appointed Representative

______________________ Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
50 College Road, NE
Bolivia, North Carolina 28422

Consent for Release of Information

CLIENT:

DATE:

REOCRD NUMBER:

I hereby authorize ____ to
(Name of Provider)
release specified information in my patient records to: BRUNSWICK INTERAGENCY PROGRAM.

____

____

____

____

For Specific: Establishing eligibility and updating information for the records.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information, I hereby acknowledged that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

______________________________ Client

______________________________ Witness

OR

______________________________ Legal Appointed Representative

______________________________ Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
50 College Road, NE
Bolivia, North Carolina 28422

Consent for Release of Information

CLIENT:

DATE:

REOCRD NUMBER:

I hereby authorize ____ to
(Name of School)
release specified information in my patient records to: BRUNSWICK INTERAGENCY PROGRAM.

____
____
____
____

For Specific: Establishing eligibility and updating information for the records.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information, I hereby acknowledged that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

______________________ Client

______________________ Witness

OR

______________________ Legal Appointed Representative

______________________ Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK TRANSIT SYSTEM, INC. TRANSPORTATION INFORMATION

- Transportation to Brunswick Interagency Program (BIP) is available through Brunswick Transit System., Inc. (BTS)
- If you wish to access this service complete the attached form and return to Jessica Thornton in the main office at BIP.
- The cost of this service is a FLAT RATE of $65.00 per month, billed by BIP, regardless of the number of days service is provided.
- Payment can be made by Cash, Check or Money Order. Payments by check or money order must be made payable to Brunswick Interagency Program (BIP).
- If you have any questions or concerns about transportation fees, please contact Jessica Thornton at (910) 755-7375.
- Seating is limited so be consistent with your ridership. Not riding for 30 calendar days or more could result in loss of your seat.
- Call Brunswick Transit System (BTS) to cancel any ride at leaser 2 hours in advance to avoid "NO SHOWS" that could potentially cost you your seat. Three (3) "NO SHOWS" in 30 days can result in suspension of service.
- Brunswick Transit System (BTS) contact number is (910) 253-7800.
- Once you are a passenger, please share any safety concerns with your driver and with a representative from Brunswick Interagency Program at (910) 755-7364 or LeAnn Cecil, Director of BIP at (910) 755-7381.

LeAnn Cecil, Director, BIP
cecill@brunswickcc.edu
(910) 755-7381

Jessica Thornton, BIP Transportation
thorntonj@brunswickcc.edu
(910) 755-7375

BTS BRUNSWICK TRANSIT SYSTEM

PASSENGER TRNSPORATION REQUEST Date of Request: ____________________

Please use this for **recurring (subscription)** passenger requests. All requests must be submitted to BTS for authorization and scheduling. **Submitting any for does not guarantee scheduling.**

Responsible Agency: ____________________

Person submitting request: ____________________ Telephone: ____________________

Passengers Last Name: ____________ First Name: ____________ MI: ______

Pick-up Address (House/Apt/Trailer number and Road name):

____

____

Special Direction: ____________________

____

Telephone Number: ____________________ Other Number: ____________________

Is a lift van required? Yes ___ No ___ Is an attendant or other assistance provided? Yes _____ No____

If a wheelchair will be used, please specify f it is standard, motorized, extended, etc. (to determine space requirements): ____________________

BTS follows all Federal and State laws governing transportation of children. Parents are responsible for federally approved child seats where applicable.

Destination: ____________________ Complete Address: ____________________

____

Days of the week transportation is requested: (Circle appropriate days):

Monday Tuesday Wednesday Thursday Friday

Arrival Time : ____________________ Departure Time (if applicable): ____________________

Date Transportation will begin: ____________________ Date Transportation will end: ____________________

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

I, ____ am the legal guardian of

________________________________ as adjudicated by law. I will submit a copy of formal documentation to the Brunswick Interagency Program within 30 days of my signature.

_________________________________   ______________

Parent or Guardian   Date

_________________________________   ______________

Witness   Date

I, ___________________________________ am my own legal guardian.

_________________________________   ______________

Witness   Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

As a participant, or the legal responsible person for a participant of Brunswick Interagency Program, I have received a copy of the Client Rights pamphlet. I have been informed of the facts concerning my rights.

______________________________	__________________
Participant's Name	Chart Number

____

Participant/Legal Responsible Person

____

Witness

____

Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

CLIENTS RIGHTS

Client Rights forms will be completed upon admission to the program apprising students of their rights and shall be placed in his/her chart. The form will be signed by the student and/or parents/guardian following explanation of rights.

As a student of services, the following are your rights:

- You have the right to dignity, privacy and humane care.
- You have the right to be free of mental and physical abuse, neglect and exploitation.
- You have the right to treatment, including medical care and habilitation, regardless of your age or disability. The treatment you receive will be age appropriate.
- You will be offered the most appropriate and least restrictive or intrusive service alternative to meet your needs.
- You have the right to be involved in the development of an individualized treatment plan, also known as your person-centered plan.
- You will be notified in advance of all potential risks and benefits of treatment
- You have the right to be free from unnecessary or excessive medications.
- You have the right to refuse treatment at any time.
- You CANNOT be treated with electroshock therapy, experimental drugs or procedures, or undergo surgery (unless it is an emergency surgery) without your written permission.
- The use of physical restraint or seclusion CANNOT be used at BIP.
- You have the right to dispose of property.
- You have the right to make purchases.
- You have the right to vote.
- You have the right to marry and divorce.
- You have the right to a discharge plan prior to being discharged. You will receive a copy of the plan.
- No corporal punishment may be inflicted on any student at BIP.
- No demeaning, shaming or degrading language or activities will be used for punishment or behavior modification.
- No unnecessary punitive restrictions.
- No forced physical exercise to eliminate behaviors.
- No peer punishment or group punishment for individual behavior.
- No punitive work assignments.

Brunswick Interagency Program has an active "P.E.T" which is our "Participant Empowerment Team." This group of self-advocates recruit new members on an annual basis. For specific dates and meeting times, please inquire with the program director.

BRUNSWICK
COMMUNITY COLLEGE

Acknowledgment of receipt of
NOTICE OF PRIVACY PRACTICES

I, ______________________________, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies and Procedures.

____

Signature of Individual

____

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE:

______________________________ ______________________

Signature of Personal Representative Date

______________________________ ______________________

Legal Authority or Personal Representative Date

BRUNSWICK
COMMUNITY COLLEGE

Privacy Statement

Notice to individuals receiving services from Brunswick Interagency Program about how your medical information is protected, used and disclosed. Please review carefully.

All individual and family information provided during screening, admission and service is considered confidential. The disclosure of Protected Health Information (PHI) is governed by North Carolina General Statute 122C and the Health Insurance Portability and Accountability Act of 1966 (HIPPA), as well as any other applicable federal or state laws.

Exchange and use of PHI between BIP staff for the purpose of education and employment services will be permitted and based on 'need to know" guidelines and positional authority.

Disclosure of PHI outside of Brunswick Interagency Program is permitted when your or your legal representative signs a written authorization, or when you give your verbal authorization in an emergency situation. Any authorization for disclosure may be revoked at any time, except to the extent that action has been taken in reliance on it.

You have the right to request restriction of the disclosure of your PHI, except when Brunswick Interagency Program is required to do so. Under the following specific conditions, disclosure of information outside Brunswick Interagency Program is permitted/required by law and professional ethics without your specific authorization:

- When there is a medical or psychiatric emergency involving the health/safety of others.
- When the BIP staff are required by law to report instances of neglect or abuse of a child or disabled adult.
- When the BIP is responding to a court order.
- When the BIP is required by North Carolina Administrative Code to disclose physician information due to an incident which would cause health risk to other persons.

You also have other rights related to the use and disclosure of PHI in your medical record. These include:

- Right to request your medical record be designated as a "secure" file
- Right to inspect and request a copy of your medical record.
- Right to request amendment of any section of your medical record.
- Right to receive an accounting of disclosures that have occurred with your medical record.

Each disclosure of PHI will be documented in the medical record. You have the right to request an accounting of these disclosures. The program may mail or email information to you regarding appointment reminders, schedules or other information about community services that might be

Special Olympics
North Carolina

Welcome to Special Olympics North Carolina!

Special Olympics North Carolina (SONC) is a non-profit organization which provides sports training and competition for nearly 40,000 children and adults with intellectual disabilities. In North Carolina, 19 sports are offered on a year-round basis; sport offerings vary by local program (primarily county).

Special Olympics was created by the Joseph P. Kennedy, Jr. Foundation. Special Olympics North Carolina is authorized and accredited by Special Olympics Inc. and is licensed by the Secretary of State's office with the State of North Carolina and is a 501(c)3 organization as determined by the Internal Revenue Service.

Special Olympics athletes get continuing opportunities, to develop physical fitness, demonstrate courage, experience joy and participate in a sharing of gifts, skills and friendship with their families, other Special Olympics athletes and the community.

To become a Special Olympics athlete, contact the local program in your county. A full list of contact information is available on the Web site at www.sonc.net.

Athlete Eligibility

Special Olympics training and competition is open to every person with an intellectual disability who is at least eight years of age. There is no maximum age limit. Eligible individuals must be identified by a medical agency or professional as having an intellectual disability. Some Special Olympics athletes may also have a physical disability, but it is their **developmental** disability that qualifies them to participate in Special Olympics.

Children who are ages two through seven may participate in the Young Athletes Program (there is a different registration form available on the SONC Web site for this program).

Application to Participate Procedures

To become a new athlete or to renew every three years, the following forms need to be completed:

- ☐ **Information Form (1 page):** This form asks for basic information about the athlete.
- ☐ **Release Form (1 page):** This form goes over some important details about Special Olympics participation and requires a signature.
- ☐ **Health History Forms (2 pages):** This section captures health history in order to identify health concerns. This section must be completed by a parent/guardian or an adult athlete who is his/her own guardian. If you do not understand any parts of the form, leave them blank to discuss with a physician during the exam. The person completing the form needs to fill in their contact information on the bottom of the second page.
- ☐ **Physical Exam Form (1 page):** This form should be filled out by a licensed medical professional (physician/doctor, registered nurse practitioner, or physician assistant).

The Release Form and the Medical Form instruct you to complete other forms in certain situations. Those will be sent out to be completed on a case by case basis.

Please submit registration forms to your local program coordinator – contact information can be found at www.sonc.net.

Questions?
www.sonc.net
800-843-6276 ext. 122

Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name:________________________________

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure (in mmHg)		Vision
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Oral Hygiene	☐ Good	☐ Fair	☐ Poor	
Thyroid Enlargement	☐ No	☐ Yes		
Lymph Node Enlargement	☐ No	☐ Yes		
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Rhythm	☐ Regular	☐ Irregular		
Lungs	☐ Clear	☐ Not clear		
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+	☐ 4+
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+	☐ 4+
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R	
Cyanosis	☐ No	☐ Yes, describe		
Clubbing	☐ No	☐ Yes, describe		

Bowel Sounds	☐ Yes	☐ No			
Hepatomegaly	☐ No	☐ Yes			
Splenomegaly	☐ No	☐ Yes			
Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ	☐ LLQ
Kidney Tenderness	☐ No	☐ Right	☐ Left		
Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Abnormal Gait	☐ No	☐ Yes, describe below			
Spasticity	☐ No	☐ Yes, describe below			
Tremor	☐ No	☐ Yes, describe below			
Neck & Back Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Mobility	☐ Full	☐ Not full, describe below			
Lower Extremity Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Strength	☐ Full	☐ Not full, describe below			
Lower Extremity Strength	☐ Full	☐ Not full, describe below			
Loss of Sensitivity	☐ No	☐ Yes, describe below			

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

OR

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

ATHLETE CLEARANCE TO PARTICIPATE *(TO BE COMPLETED BY EXAMINER ONLY)*

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions.**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions.** Describe → ____________________

☐ **This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:**

- ☐ Concerning Cardiac Exam
- ☐ Concerning Neurological Exam
- ☐ Other, please describe:
- ☐ Acute Infection
- ☐ Stage II Hypertension or Greater
- ☐ O_2 Saturation Less than 90% on Room Air
- ☐ Hepatomegaly or Splenomegaly

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ Follow up with a neurologist
- ☐ Follow up with a hearing specialist
- ☐ Follow up with a physical therapist
- ☐ Follow up with a primary care physician
- ☐ Follow up with a dentist or dental hygienist
- ☐ Follow up with a nutritionist
- ☐ Other/Exam Notes:

		Name:
		E-mail:
Signature of Licensed Medical Examiner	Exam Date	Phone: License #:

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

Other Helpful Resources

The ARC of North Carolina
www.arcnc.org
1.910.493.0003

Coastal Care
www.coastalcarenc.org.
866.875.1757/910.550.2600

Disability Rights of North Carolina
www.disabilityrightsnc.org
800.662.8706

Exceptional Children's Assistance Center
www.ecac-parentcenter.org
800.962.6817

Mental Health Association of NC, Inc
www.maminc.org
888.881.0740

National Alliance and Mental Illness (NAMI)
www.naminc.org
800.451.9682

NC Care-Line
www.ncdhhs.gov/osc.careline.htm
800.662.7030

NC Care Link
www.carellink.gov
800.662.7030

NC Division of Health Service Regulation
www.ncdhhd.gov/dhsr
800.624.3004

NC Mental health Consumers Organization
www.ncmhcosupports.org
800.662.3842

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.sMHS.gov
800.662.4357

Veterans Services
www.nccarelink.org
800.662.7030. or 919.733.1011 ext.216

National Council on Alcoholism and Drug Dependence
800.NCA.CALL

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
SOCIAL HISTORY

STUDENT'S NAME: ______________________________ AGE: ______________ MARITAL STATUS: _____

ADDRESS: ____

PLACE OF BIRTH: _______________________________________DATE OF BIRTH: ___________________

SOCIAL SECURITY # _________________________________ RACE: _________________________________

MOTHER'S NAME: ______________________________ EMPLOYER: ________________________________

FATHER'S NAME: _______________________________ EMPLOYER: ________________________________

LIVING ARRANGEMENTS: ____

IN HOUSEHOLD ___________ EDUCATION: ____

RELIGION: __________________________VOCATION: ____

CHILDREN: _______SIBLINGS (Number, Age, Sex) ____

IINCOME: (Work, Social Security, Disability): ____

I.Q/DIAGNOSIS: (Measure used, see Psychological for further detail):

____

____

____

PHYSICAL DESCRIPTION (Height, Weight, etc.):

____

____

____

____

LIMITATIONS:

____

____

____

____

MENTAL STATUS:

BEHAVIOR ISSUES:

SEXUAL BEHAVIOR/MALADAPTIVE/DIVIENT BEHAVIOR:

SOCIAL SKILLS:

DEVELOPMENTAL HISTORY:

CHILDHOOD DISEASES:

ILLNESSES AND ACCIDENTS (Recurring):

SPECIAL RESTRICTIONS:

MEDICATION AND ANY SIDE AFFECTS:

****

Place of Interview: ______________________________ DATE: ________________

Source of Information: ____________________________

Intake Person's Signature: _________________________ Title: ________________

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

NORTH CAROLINA Division of Mental Health, Developmental Disabilities and Substance Use Service

Name of Individual:	**Date Completed:**
Individual's Support Coordination Agency:	

I. Risk Assessment Tool

Situational (situations, systemic issues, mental health issues, or circumstances with caregivers, family, friends or others that create the potential for risks.

Please Check	RISK ISSUES	Why is this issue a particular risk to this person?	
		Current	Within (5) Years
	Loss of caregiver of close family member		
	Loss of someone significant		
	Loss of natural supports		
	Social isolation by caregiver		
	Refusal of critical services (by the individual or the guardian)		
	Unavailable or unreliable staffing		
	Significantly compromised hygiene or appearance (especially if a change from usual)		
	Incapacitated caregiver		
	History of neglect or abuse		
	Pregnancy and parenthood		
	Compromised communication skills		
	Loss of home		
	Eviction		
	Frequency moves for seemingly unjustified reasons		
	Difficulties with relationship with landlord		
	Dangerous or threatening neighbors		

Environmental (environmental issues that create the potential for risk

Please Check	RISK ISSUES	Why is this issue a particular risk to this person?	
		Current	Within (5) Years
	Unsanitary living conditions		
	Home is in significant disrepair		
	Necessary environmental modifications not completed		

	Necessary equipment in disrepair, broken or lost	
	Unmet equipment needs	
	Equipment not being available for use	

Behavioral (personal behaviors or lifestyle choices that are considered dangerous or potentially dangerous to self or pose a risk to others)

Please check	RISK ISSUES	Why is this issue a particular risk to this person?	
		Current Years	Within five (5)
	Self -injury		
	Aggression or violence towards others		
	Assault		
	Stealing		
	Excessive self-stimulatory		
	Making significant threats to the safety of others		
	Destruction of property		
	Refusal of Necessary services		
	Poor compliance with treatments or supports		
	Elopement		
	Social Isolation		
	Compromised communication skills		
	History of poor decision-making despite being well-informed		
	Risky sexual behavior		
	Predatory behavior		
	Excessive fascination with children or sexual abuse of children		
	History of sexually aggressive or dangerous behavior		
	Fascination with fire or history of fire setting		
	Frequent job changes		
	Suicidal ideation or attempt		
	Substance abuse		
	Contacts with EMS or law enforcement (i.e. unnecessary calls to or create situations to cause others to call)		
	Criminal justice involvement		
	Multiple requests for crisis services		

Medical (Health related risks)

Please Check	RISK ISSUES	Why is this issue a particular risk to this person?	
		Current	Within (5) Years
	Multiple medical or psychiatric hospitalization in a year		
	Multiple visits to the emergency room (whether admitted or not)		
	A person living alone or with little support who takes multiple medications		

	Taking three or more medications for a chronic medical condition, including a psychiatric diagnosis with reduced supports	
	Medical benefit loss	
	Poor follow through on post hospitalization discharge orders	
	Significant changes in health or mental status	
	Significant changes in sleeping or eating patterns	
	Significant number of medical visits or a significant increase in medical visits	
	Unmet medical needs (i.e. appointments not scheduled, follow-up appointments missed)	
	Information shared with medical personnel by support staff is inadequate (i.e. reason for referral)	
	Poor compliance or non-compliance with medical regime	
	Refusal of services	
	Inability to tolerate a medical examination/procedure	
	Multiple falls/fractures	
	Mobility impairment	
	Significant weight gain or loss	
	Swallowing disorders	
	History of choking and/or aspirations	
	Skin breakdown	
	Obesity	
	Compromised communications skills (especially in relation to being able to indicate physical pain)	
	PICA	
	Lifestyle choices that negatively affect health (i.e. smoking, drinking when contraindicated by medications)	

Financial risks (mismanagement of finances by self or others or loss of income

Please Check	RISK ISSUES	Why is this issue a particular risk to this person?	
		Current	Within (5) Years
	Loss of job		
	Loss of benefits or significant reduction in benefits		
	Indebtedness		
	Loaning money to others		
	Excessive gambling		
	Financial housing cost		

Other risks (Identified risks not otherwise mentioned above			
Please Check	**What is the issue?**	**Why is this issue a particular risk to this person?**	
		Current	**Within (5) Years**

II. Summary of Incident Reports

Reportable Incidents (summarize by type of incidents, the number of reportable incidents, or attach other printout summary of reportable incidents)		
TPYE OF INCIDENT	**Number of Incidents**	**COMMENTS**

Other explanatory Information:

Individuals participating in the completion of this tool.

Name	Title:
______________________	______________________
______________________	______________________
______________________	______________________