Boston University College of Health & Rehabilitation Sciences: Sargent College
Center for Psychiatric Rehabilitation

Stephanie Cummings, Administrative Manager
Recovery Services Division
940 Commonwealth Avenue West
Boston, Massachusetts 02215
T: 617-353-3549 F: 617-353-7700
stephc13@bu.edu
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RECOVERY SERVICES

STUDENT APPLICATION PACKET

Instructions: Please complete all 8 parts of your Student Application Packet, and fax it to Stephanie Cummings at (617) 353-7700. After receiving your packet, she will contact before the start of the upcoming semester to arrange a brief interview. If you have any questions about the application process or services offered at the Center for Psychiatric Rehabilitation, please refer to the "Living Well" section of our webpage at cpr.bu.edu or contact Stephanie Cummings at (617) 353-3549 or stephc13@bu.edu.

Date Sent:

PART 1: CONTACT INFORMATION

Name:

[Last Name] **[First]** **[Middle Initial]**

Address:

[Street] **[Apartment/Suite Number]**

[City/Town] **[State]** **[Zip Code]**

Phone:

[Home] **[Cell]**

Email:

Date of Birth:

[MM/DD/YYYY]

PART 2: CURRENT MEDICAL & PSYCHIATRIC CONDITIONS

Current Medical Conditions

☐ AIDS/HIV	☐ Heart Attack/Failure
☐ Cognitive	☐ Hemophilia
☐ Anaphylaxis	☐ Hepatitis _____ (A,B or C)
☐ Anemia	☐ High Blood Pressure
☐ Angina	☐ High Cholesterol
☐ Arthritis/Gout	☐ Irregular Heartbeat
☐ Artificial Heart Valve	☐ Kidney Problems
☐ Asthma	☐ Liver Disease
☐ Blood Disease	☐ Low Blood Pressure
☐ Breathing Problem	☐ Lung Disease
☐ Cancer	☐ Osteoporosis
☐ Chest Pain	☐ Stomach/Intestinal Disease
☐ Clinical Obesity	☐ Stroke
☐ Convulsions	☐ Tuberculosis
☐ Diabetes	☐ Ulcers
☐ Dizziness or Fainting Spells	☐ Other:_____
☐ Ear Problems/Hearing Loss	☐ Other:_____
☐ Emphysema	☐ Other:_____
☐ Epilepsy or Seizures	☐ Other:_____
☐ Eye Problems	☐ Other:_____

Current Psychiatric Conditions

☐ Alcohol/Substance Abuse	☐ Panic Disorder
☐ Anxiety Disorder	☐ Personality Disorder (Borderline, Antisocial, etc.)
☐ Asperger's Disorder	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Attention Deficit/Hyperactivity Disorder (ADHD/ADD)	☐ Schizophrenia
	☐ Seasonal Affective Disorder (SAD)
☐ Autism	☐ Sexual & Paraphilic Disorder
☐ Bipolar Disorder	☐ Sleep & Wake Disorder (Insomnia, Narcolepsy, etc.)
☐ Depression	☐ Other:_____
☐ Dissociative Disorder	☐ Other:_____
☐ Hoarding Disorder	☐ Other:_____
☐ Hypochondriasis	☐ Other:_____
☐ Obsessive-Compulsive Disorder (OCD)	☐ Other:_____

PART 3: DEMOGRAPHIC SURVEY

1. **To which gender identity do you most identify?**
   - ☐ Female
   - ☐ Male
   - ☐Transgender Male
   - ☐ Prefer to self-describe_____
   - ☐ Gender Variant/Non-Conforming
   - ☐Transgender Female
   - ☐ Prefer not to say

2. **What is your date of birth?** _____ (MM/DD/YYYY) **Age as of April 2017?** _____

3. **Ethnicity origin (or Race): Please Specify your ethnicity**
   - ☐ White
   - ☐ Hispanic or Latino
   - ☐ Black or African American
   - ☐ Native American or American Indian
   - ☐ Asian/Pacific Islander
   - ☐ Other (please specify): _____
   - ☐ Prefer not to answer

4. **What is the highest degree or level of school you have completed?** *If currently enrolled, highest degree currently enrolled, highest degree received.*
   - ☐ No schooling
   - ☐ Less than High School
   - ☐ High School Diploma/GED
   - ☐ Some College
   - ☐ 2-Year College Degree (Associates)
   - ☐ 4-Year College Degree (BA, BS)
   - ☐ Master's Degree
   - ☐ Doctorate Degree
   - ☐ Professional Degree (MD, JD)

5. **What is your current marital status?**
   - ☐ Single/Never Married
   - ☐ Married
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Prefer not to answer

6. **What is your current employment status?**
   - ☐ Employed Full-time (40+ hours per week)
   - ☐ Employed Part-time (1-39 hours per week)
   - ☐ Not Employed, Looking for Work
   - ☐ Not Employed, Not Looking for Work
   - ☐ Retired
   - ☐ Disabled, Not Able to Work
   - ☐ Prefer not to answer

7. **What is your current religious affiliation?**
   - ☐ Christian
   - ☐ Jewish
   - ☐ Buddhist
   - ☐ Muslim
   - ☐ Hindu
   - ☐ Unaffiliated
   - ☐ Other (please specify): _____
   - ☐ Prefer not to answer

8. **Military Status:**
   - ☐ No, Military Service
   - ☐ Armed Forces – Reserves
   - ☐ Dependent Family Member
   - ☐ Prefer not to answer
   - ☐ Armed Forces – Active Duty
   - ☐ Armed Forces/National Guard
   - ☐ National Guard – not mobilized
   - ☐ other (please specify): _____

9. **Citizenship Status**
   - ☐ Us Citizen by Birth (Native)
   - ☐ Permanent Resident
   - ☐ Non-resident Allen- Visa type_____Exp. Date:_____
   - ☐ Us Citizen Naturalized

PART 4: EMERGENCY CONTACT INFORMATION

In case of a *medical emergency*, please contact the following person:
Name:
Relationship:
Address:
Phone (Primary):
Phone (Secondary):

In case of a *personal emergency*, please contact the following person:
Name:
Relationship:
Address:
Phone (Primary):
Phone (Secondary):

PART 5: PROFESSIONAL SUPPORTS

Primary Care Physician
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):

PART 6: PROFESSIONAL SUPPORTS CONTINUED

Psychiatrist
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):

Therapist
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):

PART 7: INTERESTS & GOALS

Please explain your interest(s) in Recovery Services at the Center:

PART 7: INTERESTS & GOALS

Please explain your recovery goals and discuss what kind of help and support you think you will need to accomplish those goals:

PART 8: Authorization for Two-Way Release of Information for Medical and Psychiatric Records

1. Name of person/facility/agency other than or at Boston University to receive or release information:

_____

2. Information I give permission to release or receive: _____

3. This release will expire on *(specify a date, time period or an event)* _____.
If nothing is specified, it will expire when I am no longer receiving services at Boston University.

I understand that I have a right to withdraw this release at any time. If I withdraw this authorization, I must do so in writing and present it to the address above. I understand that if I pull my release of this information, it will not apply to information that has already been given before I withdrew this permission.

I understand that once the above information is disclosed to a person, facility or agency outside Boston University, the person who receives this information may disclose it again and the information may not be protected by federal or state privacy laws or regulations. I understand that I may choose whether or not to sign this form and that I do not need to sign this form in order to receive rehabilitation and recovery services from Boston University and/or the other person, facility or agency. However, without the ability to share or obtain information, Boston University and/or the other person/agency may not be able to provide effective rehabilitation and recovery services.

_____

Your Signature or Personal Representative's Signature **Date**

_____

Print Name of Signer

If signed by a Personal Representative:
Type of authority (e.g., court appointed, custodial parent) _____

***This form must be completed in full to be considered valid.*
Distribution of copies: original to Boston University; copy to Individual or Personal Representative; copy to named person/facility/agency.

PART 9: MEDICAL & PSYCHIATRIC INFORMATION FORM

Instructions for Part 9:

The Medical & Psychiatric Information Form on the next page (PAGE 9) needs to be completed by your primary care physician or psychiatrist, and faxed to <u>Stephanie Cummings</u> at (617) 353-7700.

(See Next Page for Medical & Psychiatric Information Form)

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MEDICAL & PSYCHIATRIC INFORMATION FORM

Instructions: Please fax completed form to Stephanie Cummings at (617) 353-7700.

Patient's Name:

[Last] **[First]** **[Middle Initial]**

Physician/Psychiatrist's Name:

[Last] **[First]** **[Middle Initial]**

Medical Facility/Clinic/Program:

Date of Last Physical Exam:

Diagnosis:

Please provide full DSM or ICD-10 Code:

Initial date of diagnosis: **Date of Last Clinical Contact:**

Does patient have any physical limitations that would prevent him/her from participating in an exercise program?

☐ **Yes** ☐ **No**

1) Weight: _____ lbs. **2) Height: _____** **3) BMI: _____**

Psychiatric Medication(s)

Other Medication(s)

Please List Any Restrictions/Recommendations:

Physician/Psychiatrist's Signature: **Date:**