Patient Information Form

*Please Note: For patients over 18, the patient must complete a consent form for any person authorized to discuss treatment or care including parents or legal guardians.*

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Patient cell phone</td>
<td></td>
</tr>
</tbody>
</table>

**Caregiver’s name and relationship to patient:**

<table>
<thead>
<tr>
<th>Caregiver Type</th>
<th>Relationship</th>
<th>Cell #</th>
<th>Legal guardian?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Caregiver</td>
<td>Relationship</td>
<td></td>
<td>□YES □NO</td>
</tr>
<tr>
<td>Secondary Caregiver</td>
<td>Relationship</td>
<td></td>
<td>□YES □NO</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>□YES □NO</td>
</tr>
</tbody>
</table>

*Please complete a separate consent form for each person or clinician listed below that you would like for us to coordinate care or discuss patient information with including the patients Primary Care Physician.*

**Primary Care Physician:** Name:

Phone #:

**Individual Therapist:** Name:

Phone #:

Email address:

**Psychiatrist:** Name:

Phone #:

Email address:

**Probation Officer:** Name:

Phone #:

Email address:

**DCF Case Worker:** Name:

Phone #:

Email address:

**Other: (i.e. school counselor, family therapist etc.)**

Name:

Relationship to patient:

Phone #:

Email address:

**Other:**

Name:

Relationship to patient:

Phone #:

Email address: