FENWAY HEALTH

Trans Youth Clinic Medical Intake Appointment

Please bring in or be prepared to discuss the following information for your child.

Medical Information

Name, address, and phone number for your child's primary care provider/pediatrician

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of Protected Health Information form (attached) for this provider.

List any medications prescribed by this provider

Medication Name	Dose and How Often Taken	Reason For Medication

Please write any additional medications on another page or bring in a list from the provider's office. Bring in a list or be prepared to discuss any current medical conditions, and be prepared to discuss history of childhood illnesses, accidents, hospitalizations, vaccines, allergies, etc.

Insurance Information

Some medications require a prior authorization. Your child's medical team will need this additional insurance information to be able to submit it. Please include a photo of your child's pharmacy insurance card

Child's Name on Insurance		Gender Marker on Insurance	
Pharmacy Benefits		Medical Insurance	
Pharmacy Member ID Number		Medical Insurance Member ID Number	
BIN Rx		Medical Insurance Group Number	
Group Rx		PCN Rx	

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Behavioral Health Information

Name, address, and phone number for your child's psychiatrist if there is one.

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of information form (attached) for this provider.

List of medications and dosages prescribed by this provider.

Medication Name	Dose and How Often Taken	Reason for Medication

Please write any additional medications on another page or bring in a list from the provider's office. Bring in a list or be prepared to discuss diagnoses currently being treated by this provider.

Name, address, and phone number for your child's individual therapist

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of information form (attached) for this provider.
Be prepared to discuss any hospitalizations, emergency department visits, or self-harming behaviors.

Name, address, and phone number for the family therapist and/or other provider(s)

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of information form (attached) for this provider.

FENWAY HEALTH

Family Structure & Guardianship

Who does this child live with?

Name	Relationship to Child

If the child lives outside the parent/guardian's home, provide contact details for the place of residence.

Residence Name	
Primary Contact	
Phone Number	
Address	
City, State, Zip	

Name(s) and contact information for all adults who have the legal right to consent or object to treatment.

	Guardian #1	Guardian #2
Name		
Relationship		
Phone Number		
Address		
City, State, Zip		

You must provide a copy of the court documentation assigning guardianship for medical decisions to anyone other than the biological parents of the child. (i.e., adoption, divorce, separation, etc.)

Instructions for the Authorization for Disclosure of Protected Health Information. Complete a separate form for each provider

1) Enter your information
2) Enter your outside provider information
3) Our information is pre-filled in
4) Check the boxes "to allow bi-directional communication with service provider" AND "Share medical records with another provider"
5) Mark next to All records
6) INITIAL next to any pertinent categories. Please always initial next to the 2 bullets listing Behavioral Health Information
7) Sign and date. Return signed forms to transyouth@fenwayhealth.org or a member of your care team