



Today's Date: _____

Client Name: _____ DOB: _____

Primary Language: _____ Secondary Language: _____

Race/Ethnicity: _____

Primary Insurance Name: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

SSN: _____

IDENTIFYING INFORMATION

Home Address: _____

City: _____ Zip Code: _____ Home Phone: _____

Email Address: _____

School/Grade: _____

Legal Guardian Name/Phone: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship to Client: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

Physician's Name/Phone: _____

Others in the Home (Names/Relationship to Client/Ages if appropriate): _____

Significant Others Involved with Client:

Have you/your child ever had a vision test? If yes, what were the results?

Are glasses/contacts required? If so, when should they be worn?

Have you/your child ever had a hearing test? If yes, what were the results?

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services: _____

Recent Treatment History (last 12 months): _____

Pertinent Medical Issues: _____

Any current infectious disease(s)? _____

Client Medications: _____

Pharmacy: _____

Pharmacy Address: _____ Pharmacy Number: _____

Other Active Service Providers (last six months): _____

Court Involvement and/or Pending Charges: _____

Client Name: _____

Record Number: _____

CONSENTS/RIGHTS INFORMATION

1. Consent for Electronic Signature (Optional)

This is to certify my request for an electronic signature. Through the use of an electronic signature, I agree that the information I provide is accurate and complete to the best of my knowledge. I agree that the electronic signatures appearing on this agreement (and other documents that require electronic signatures provided by Path Behavioral Healthcare) are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility. Please note that you may withdraw your consent to sign documents electronically at any time. In order to withdraw consent, you must notify Path Behavioral Healthcare that you wish to withdraw consent and request that your future documents be prepared in paper format.

Client/Parent/Guardian: _____

Date: _____

2. Consent for Treatment

I hereby give my consent for **Therapist** to provide mental health services to me/my child. I have been informed of the scope and purpose of the service and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Parent/Guardian: _____

Date: _____

3. Financial Release

I understand that **Therapist** may use confidential information about me to bill and be paid for services. I hereby consent for **Therapist** to release information to the billing agent, **Integrity Support, Inc.** and its contracted clearinghouse, and/or to the funding source, and for the funding source to release information to **Therapist** and **Integrity Support, Inc.** for this purpose.

Client/Parent/Guardian: _____

Date: _____

4. Permission to Transport

I hereby grant permission for **Therapist**, to provide transportation to my child, and agree to hold **Therapist** harmless for any accident/injury that results from the provision of transportation.

Client/Parent/Guardian: _____

Date: _____

5. Permission to Seek Emergency Medical Care

I hereby give consent for **Therapist**, to seek and sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that **Therapist** will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Parent/Guardian: _____

Date: _____

6. Client Rights/Grievance Policies (See Handout)

I have received and had explained to me the Client Rights handout. **Therapist** gave me this

Client Name: _____
handout and verbally explained my rights as a client.

Record Number: _____

Client/Parent/Guardian: _____

Date: _____

7. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. **Therapist** gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: _____

Date: _____

8. Telemedicine Consent

I agree to participate in Telemedicine services offered through Path Behavioral Healthcare including outpatient therapy and medication management. I understand that I have the option to schedule appointments with Path Behavioral Healthcare's Psychiatrist, Medical Psychologist, Psychiatric Nurse Practitioner, or Outpatient Therapist in another Path Behavioral Healthcare office that supports an on-site practitioner. However, such a face-to-face appointment may require a wait time from one to 4 weeks and commuting from out of town will be at my own expense.

Client/Parent/Guardian: _____

Date: _____

9. Communication

I understand that one of my rights is to be able to choose how I am contacted.

I *do do not* give permission for **Therapist** to contact me at work.

Furthermore, I *do do not* give permission for **Therapist** to leave voice messages for me at *home work both neither*.

Client/Parent/Guardian: _____

Date: _____

10. Drug Testing Consent **Required for Intensive Outpatient Program** 13 and up

I hereby agree, upon a request made under the drug/alcohol testing policy of Path Behavioral Healthcare, to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to discharge after consultation of treatment team. I further authorize and give full permission to have the Company and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company. I UNDERSTAND THAT THE COMPANY WILL REQUIRE A DRUG SCREEN AND/OR ALCOHOL TEST UNDER THIS POLICY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL, AND I AGREE TO SUBMIT TO ANY SUCH TEST. I ALSO UNDERSTAND THAT I AM SUBJECT TO RANDOM ALCOHOL AND/OR DRUG TESTS.

Client/Parent/Guardian: _____

Date: _____

I, **Therapist**, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Client/Parent/Guardian of the client to be served.

Signature: _____

Date: _____

Print: _____



Path Behavioral Healthcare

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Shreveport Location: 6811 Fairfield Ave. Shreveport, LA 71106 318.216.5088 (phone), 318.670.3975 (fax)
New Iberia Location: 177 Duperier Avenue New Iberia, LA 70560 337.419.3586 (phone), 337.753.7454 (fax)

Client and Family Orientation Checklist

The following information has been provided as part of the consumer orientation. Signatures below indicate that each area has been fully explained and is understood by the consumer. The recipient handbook has also been provided in the orientation.

Services provided, days and hours of operation, expected level of participation

Client Rights and Rights of Minor Patients

Code of Ethics/Conduct

Grievances and Appeal Procedures

Discharge Procedure

Confidentiality/HIPAA

Education about advanced directives

Use of Seclusion and Restraint

Policy on Tobacco Use

Medications

Illegal Drugs

Weapons

Religion and Spirituality

After Hours Crisis Line

Emergency Preparedness

Privacy Statement

Identification of the person responsible for service coordination

Program Rules

Person-Centered Plan Development/Collaboration during initial assessment every 6 months (or as needed)

Assessments conducted by LMHP on admit and yearly (or as needed)

Collaboration with PCP, school, and appropriate referral sources (with authorization to release)

Client Name / Signature:

Legal Guardian Name / Signature:

LMHP Name / Signature:

Date:



Telehealth Services

Telehealth involves the use of electronic communications to enable Path Behavioral Health to connect with individuals using interactive audio, video, telephone and/or other audio/video communications and includes the practice of delivery of services such as assessments, diagnosis, consultation, transfer of medical and clinical data, psychoeducation, referral to resources, psychotherapy/therapy, and additional Mental Health Rehabilitation (MHR) services approved by Louisiana Department of Health (LDH).

Considerations regarding Telehealth Services:

Comfort with technology varies among people and therefore, use of telemental health or “telehealth” requires a comfort and proficiency with technology. Path Behavioral Health will work to assess with you whether you might be a fit for telemental health prior to engaging in services.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality about my treatment and related communications via telehealth. The laws that protect confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during my treatment is generally confidential with exceptions for safety and legal implications, as expressed in the Informed Consent document.
2. I understand that there are risks associated with participating in telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of Path Behavioral Health, that my sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and Path Behavioral Health may occur via telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each telehealth session Path Behavioral Health is required to verify my full name and current location.
6. I understand that in some instances telehealth may not be as effective or provide the same results as in-person treatment. I understand that if Path Behavioral Health believes I would be better served by in-person, it will be discussed with me and services will be transitioned to in-person with Path Behavioral Health. If such services are not possible because of distance or hardship, I will be referred to other providers who can provide such services.
7. I understand that while telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that telehealth is effective for all individuals. Therefore, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.
8. I understand that some telehealth platforms allow for video or audio recordings and that neither I nor Path Behavioral Health may record the sessions without the other party's written permission.

Client Name:

Record Number:

9. I understand that Path Behavioral Health will make reasonable efforts to provide me with emergency resources in my geographic area.

Emergency Procedures Specific to Telehealth Services

If you have a mental health emergency, Path Behavioral Health encourage you not to wait for communication back from provider, but do one or more of the following:

- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice (nearest emergency room is recommended).
- Call Path Behavioral Health Crisis Line

There are additional procedures that we need to have in place specific to telehealthservices. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and/or telehealth services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. This person is the person indicated in the informed consent processed identified as your emergency contact.
- You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.
- Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

I have read and understand the information provided above, have discussed it with Path Behavioral Health and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Client/Parent/Guardian Signature:

Client Name:

LMHP Signature:

Verbal Consent Obtained

Path Behavioral Health reviewed Telehealth Consent Form with client, client understands and agrees to the above terms, and client has verbally consented to receiving services from Path Behavioral Health via Telehealth.

Staff Name:

Date of Verbal Consent:

Client Name:

Record Number:



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Path Behavioral Health

AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF INFORMATION

CLIENT NAME: _____ MR#: _____

Insurance ID#: _____ DOB: _____

I hereby request and authorize **Path Behavioral Health** or contracted agent to release and exchange information to:

(Name of agency/person/facility or program authorized to use or disclose information)

Person/Agency _____ Address _____ Phone No. _____ Fax No. _____
: _____ : _____ : _____

(The following information will be released or exchanged (mark all that apply))

Psychological Evaluation	Medication History
Psychiatric Evaluation	Admissions Assessment
Progress Note **Does not include client session notes from assigned therapist(s) **	Insurance Information
Discharge Summary	HIV/AIDS information
Treatment Plan and Diagnosis	Labs
Alcohol/Drug treatment	IEP, 504 Plan, Grades
Emergency Contact	Other (specify):

Time Frame of Information to be Released _____ to 90 days post D/C.

The purpose of this disclosure is for: ☐ Assistance with treatment ☐ Referral ☐ Emergency Contact ☐ Collaboration ☐ Client request

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by the laws. All information and records that identify a person who has HIV/AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to state law shall be strictly confidential.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on the consent. In any event, if not revoked earlier this authorization expires automatically one year (365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Path Behavioral Health** will begin and continue client's treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily, and without coercion. I understand health insurance and information will be disclosed.

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement requesting revocation signed and dated by the above name person or guardian.

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Staff, if revoked verbally _____ Date: _____



PATH
Behavioral Healthcare

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Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement requesting revocation signed and dated by the above name person or guardian.

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Staff, if revoked verbally _____ Date: _____



CONFIDENTIAL EXCHANGE OF INFORMATION FORM

PATIENT NAME: _____ DOB: _____

A. Treating Behavioral Health Clinician/Facility Information:

Path Behavioral Health: Lafayette Location: 917 General Mouton Lafayette, LA 70501 337-232-9457, 337-232-9459 (fax) Opelousas Location: 1211 W. Vine St. Suite C Opelousas, LA 70570 337-678-3201, 337-678-3203 (fax) Slidell Location: 350 Gateway Dr. Slidell, LA 70461 985-707-1410, 985-707-1415 (fax) Shreveport Location: 6811 Fairfield Avenue Shreveport, LA 71106 318-216-5088; 318-670-3975 (fax) New Iberia Location: 177 Duperier Avenue New Iberia, LA 70560 337.419.3586 (phone), 337.753.7454 (fax)

B. P/Medical Practitioner or Other Behavioral Health Practitioner/Facility Information:

Name: _____ Phone: _____
Address: _____ Fax: _____

C. Patient Clinical Information:

1. The patient is being treated for the following behavioral health condition(s):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ADHD/ Behavior Disorder | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Psychotic Disorder | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Depressive Disorder | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Adjustment Disorder |
| <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Other: _____ | | |

2. The patient is taking the following prescribed psychotropic medication(s):

<input type="checkbox"/> Antidepressant	Name: _____	Dose: _____	Frequency: _____
<input type="checkbox"/> Mood Stabilizer	Name: _____	Dose: _____	Frequency: _____
<input type="checkbox"/> Stimulant	Name: _____	Dose: _____	Frequency: _____
<input type="checkbox"/> Anxiolytic	Name: _____	Dose: _____	Frequency: _____
<input type="checkbox"/> Antipsychotic	Name: _____	Dose: _____	Frequency: _____
<input type="checkbox"/> Other (Indicate medication name): _____			

3. Expected length of treatment: ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

4. Coordination of care issues/Other relevant information impacting care: _____

Date Mailed or Faxed to Other Practitioner/Facility: _____

(PLACE A COMPLETED COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD)

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last 90 days post D/C. I understand that I may revoke my consent at any time.

Patient Signature

Date

I do not want to have information shared with:

- | | |
|---|--|
| <input type="checkbox"/> My PCP/Medical practitioner | <input type="checkbox"/> I am not currently receiving services from a PCP/ other medical practitioner |
| <input type="checkbox"/> My other behavioral health practitioner(s) | <input type="checkbox"/> I am not currently receiving services from any other behavioral health practitioner |

Behavioral Health Practitioner/Facility Representative Signature

Date

For Patient Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

THIS IS NOT A REQUEST FOR MEDICAL RECORDS



Health and Wellness Questionnaire

People who are prescribed atypical antipsychotics are at increased risk of developing metabolic syndrome. Many individuals with schizophrenia, bipolar disorder, and psychotic disorder are prescribed atypical antipsychotics to treat the serious symptoms of these disorders. Depression is also linked to higher risk of diabetes and cardiovascular disease. It's critical that these individuals have their weight, blood sugar, blood pressure, and cholesterol routinely monitored by their doctor along with education on healthy lifestyle choices.

Behavioral Health Provider Name: Path Behavioral Healthcare	Completing Staff Member Name:	Date Completed:
Member Name:	Insurance ID:	Date of Birth:
Primary Care Provider Name:		

1. Living Situation

Where do you currently live?					
<input type="checkbox"/> House/Apartment	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Shelter	<input type="checkbox"/> Homeless		
Who do you live with?					
<input type="checkbox"/> Alone	<input type="checkbox"/> Roommate	<input type="checkbox"/> Partner/Spouse	<input type="checkbox"/> Adult Family	<input type="checkbox"/> Minor Children	<input type="checkbox"/> Supervised

2. Hospital/Office Visit History

In the past 12 months how many times have you:				
	Never	1 – 2	3 – 5	6 or More
Visited a doctor's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gone to the emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stayed overnight in a hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Cholesterol checked

Date of last test:
If unknown: recommendation is to follow up with PCP

4. Glucose Levels checked

Date of last test:
If unknown: recommendation is to follow up with PCP

5. Vitals

Date taken:						
Temp:	Pulse:	BP:	Height:	Weight:	BMI:	Waist:



Health and Wellness Questionnaire

6. Social Activity

How often do you do the following:				
	Never	Rarely	Sometimes	Frequently
Receive invitations to go out and do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk to someone about personal/family problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Physical Activity

How often do you do the following:				
	Never	Rarely	Sometimes	Frequently
Go to the gym	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk or run	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Preventative Test History

When was the last time you've had:						
	Never	Less Than 1 Year	1 – 2 Year	3 – 4 Year	5 + Year	Don't Know
Colon cancer screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pap test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Chronic Condition History

Do you have any of the following conditions:						
	Never	In the Past	Currently Diagnosed	Currently Taking Medication	Under Medical Care	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis/COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Considering your age, how would you rate your overall health:						
Poor	Not Good	Average	Good	Excellent		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		



Health and Wellness Questionnaire

10. Wellness Education: Please check the topics you would like additional information on:

Topics	Yes	No	Uncertain
Nutrition			
Healthy Cooking			
Physical Activity/Exercise			
Smoking Cessation			
Stress Management			
Recovery Activities			
Peer Support			
Medical Management			
GED			
Vocation/PreVocation			
Other, specify:			