Boston Children's Hospital
Until every child is well
Adolescent Substance Use and Addiction Program

Patient Information Form

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

Patient Name:			
Date of Birth:			
Patient cell phone:			
Caregiver's name and relationship to patient:			
Primary Caregiver:		Relationship:	
Cell #:	Legal guardian?	□YES	□NO
Secondary Caregiver:		Relationship:	
Cell #:	Legal guardian?	□YES	□NO
Other: Please list any additional legal guardian's and relationship to the patient			
Name:		Relationship:	
Cell #:	Legal guardian?	□YES	□NO

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:	