

Child/Adolescent Demographic Form

Alaska Psychiatric Institute
Telebehavioral Healthcare Services
(Provider to Complete and Fax to 269-7129)

Date:		Person Completing Form:	
Patient's Name: Last		First	Middle Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:	Birthplace:	
Patient's Address:		Language Spoken at Home:	
Biological Mother's Full Name:		Biological Father's Full Name:	
If applicable, Guardian's Full Name:		If applicable, Guardian's Full Name:	
Mailing Address:		Contact Phone:	
Is the Child/Adolescent Attending School? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, School: Primary Teacher:		Does the Child/Adolescent have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race:			
<input type="checkbox"/> White <input type="checkbox"/> Black, African American <input type="checkbox"/> Hispanic, Latino, or Spanish Origin <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Somoan <input type="checkbox"/> Other Pacific Islander: <input type="checkbox"/> Asian Indian <input type="checkbox"/> American Indian	<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:	<input type="checkbox"/> Alaska Native <input type="checkbox"/> Aleut <input type="checkbox"/> Eskimo <input type="checkbox"/> Alutiq <input type="checkbox"/> Yupik <input type="checkbox"/> Inupiat
Tribal Affiliation:		Tribal Affiliation:	
Emergency Contact:		Emergency Contact Phone Number:	
Patient's Clinic Location:		Local Clinic Provider:	
Referred By:		Current Medical Conditions and Allergies:	
Primary Health Care Provider :			
WHAT DO YOU WANT FROM THIS CONSULTATION? – Please be brief:			
REFERRAL CONCERNS RELEVANT TO THIS CONSULTATION – Please be brief:			
Records to Attach			
Most Recent Medical Exam by Primary Care Provider		Therapist Intake/Mental Health Evaluation (if available)	
Current Medication List		Treatment Plan (if available)	
Recent Emergency Room Visit Record if Applicable		Most Recent Progress Notes	