

RAE A. LITTLEWOOD, PH.D.

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CLINICAL PSYCHOLOGIST

Intake Form for Pre-surgical Psychological Evaluation  
Renal Transplant Recipients & Donors

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age : \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Preferred Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

SSN: \_\_\_\_\_

(Your SSN is needed in order to bill Presbyterian for your evaluation.)

DEMOGRAPHIC INFORMATION

Education: Highest grade level completed or Year graduated high-school/GED: \_\_\_\_\_

Please describe any higher education that you have completed: \_\_\_\_\_

\_\_\_\_\_

Current Occupation/Employer & Duration: \_\_\_\_\_

If on disability, list reason for disability and how long you have been receiving disability benefits:

\_\_\_\_\_

Describe prior employment history: \_\_\_\_\_

\_\_\_\_\_

Relationship Status: \_\_\_\_\_ Duration of Current Relationship: \_\_\_\_\_

Partner/Spouse's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Partner/Spouse's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Children's Names & Ages: \_\_\_\_\_

Who lives in your home with you?

PSYCHOLOGICAL HISTORY

Please describe the types of stress you currently experience in your daily life:

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Please describe any times in your life where you have experienced depression, anxiety, or other emotional difficulties:

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Please describe what you do to manage stress:

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Have you experienced any of the following as a child or an adult? (Circle Yes or No for each item.)

Sexual Abuse:	NO	YES	Physical Abuse:	NO	YES
Emotional Abuse:	NO	YES	Victim of Crime:	NO	YES
Eating Disorder:	NO	YES	Suicide Attempt:	NO	YES

Are you **currently** receiving psychotherapy or psychiatric medication? NO YES

**If YES**, please write down the name of the provider, any medications you take for psychological symptoms, and the type of problems you are addressing in treatment:

Have you seen a psychologist, psychiatrist, or counselor in the past? NO YES

If YES, please provide the names of the providers, the approximate dates seen, and problems you addressed in treatment:

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Has anyone in your family of origin (mother, father, siblings, grandparents, uncles, aunts, 1st cousins) been diagnosed or treated for problems with alcohol or drugs?

If YES, please list here and describe what you know about the substance use problem:

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Has anyone in your family of origin (mother, father, siblings, grandparents, uncles, aunts, 1st cousins) been diagnosed or treated for a mental health issue, like depression, anxiety, bipolar disorder (i.e., manic-depression), schizophrenia, or another emotional problem?

If YES, please list here and describe what you know about the issue:

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#### HEALTH BEHAVIORS & MEDICAL HISTORY

How often do you drink alcohol? \_\_\_\_\_

On average, how much do you drink on each occasion? \_\_\_\_\_

Do you use tobacco? NO YES Cigarettes per day? \_\_\_\_\_

Do you drink caffeine? NO YES Quantity per day? \_\_\_\_\_

Do you use drugs? NO YES Type/Quantity per day? \_\_\_\_\_

Do you exercise? NO YES Type/Frequency? \_\_\_\_\_

Do you currently or have you ever had problems with alcohol or drugs or been in treatment for substance abuse or dependence?

NO YES

If YES, please describe:

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Please list any CURRENT health conditions, problems, and allergies:

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Please list PAST health problems, including major operations and hospitalizations:

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Please list ALL medications and doses you are currently taking (OR attach a list of your medications on a separate piece of paper):

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## **INFORMED CONSENT FOR PSYCHOLOGICAL EVALUATION**

Dr. Littlewood has been asked to conduct a psychological assessment of you as part of your work up to be listed for renal transplant or to be considered for renal donation. This form was written to give you information about this assessment process. This release is for the sole purpose of facilitating a psychological evaluation and not for therapy. You are therefore not a patient of Dr. Littlewood and the therapist-patient confidentiality and privilege is *not* applicable. Pre-surgical psychological evaluation is the standard of care in a comprehensive work-up for renal transplant recipients and living donors.

Psychological evaluation consists of an interview with Rae Littlewood, Ph.D. who specializes in this area. The interview includes questions about my personal history, current relationships and circumstances, health behaviors, medical history, and family history. The evaluation also includes the Personality Assessment Inventory (PAI), a widely used measure of personality.

The records of the interview and the PAI will remain in the confidential files of the psychologist, and a report is forwarded to the Presbyterian Renal Transplant Services. You will **not** receive a copy of the report pertaining to the psychological evaluation but you will have the opportunity to discuss the results of the evaluation and any recommendations that Dr. Littlewood provides to the team.

**Please read each item carefully and sign below indicating that you understand and wish to proceed with the evaluation as described above:**

- I understand that my psychological history and current psychological functioning is being evaluated in connection with my pre-surgical work-up for renal transplant or donation.
- I understand that that this informed consent is for the purpose of facilitating psychological evaluation and not for therapy. As such, there is no therapist-patient privilege or confidentiality.
- I understand that Dr. Littlewood will write a formal report about me based on the results of this assessment and that I will not have access to this report.
- I understand that records of the interview and the PAI will remain in the confidential files of the psychologist, and an evaluation report is forwarded to Presbyterian Renal Transplant Services.
- I understand that I will receive feedback from Dr. Littlewood pertaining to the results of the psychological evaluation and any recommendations that are produced from the evaluation.
- I understand that state laws require Dr. Littlewood to disclose otherwise privileged information in situations of suspected child or elder abuse, of suspected potential harm to oneself or to another, in instances where the court shall order the disclosure of privileged information, or information to a subpoena for these records.
- In consideration of Dr. Littlewood's agreement to perform this service, I release her from any liability that might directly or indirectly result from the exchange of any

information covered by this agreement.

- I agree that this is a legally binding document and that I fully understand the rights, privacy, and privileges that I waive by signing this agreement.
- I have been made aware that a **Notice of Privacy Practices** is available in the reception area at Dr. Littlewood's office.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I authorize my consent to release information regarding the results of my psychological evaluation, including a written report that summarizes this evaluation, conducted by Rae Littlewood, PhD. to:

PRESBYTERIAN RENAL TRANSPLANT SERVICES  
Physician Office Building  
Eighth floor, Suite 820  
Albuquerque, NM 87106

Signature: \_\_\_\_\_

Date: \_\_\_\_\_