Approved: Yes / No

Signature: ____ Bed Date: _________________

SERENITY HOUSE REFERRAL FORM

NAME: _______________________________ **DATE:** _________________________

SSN: _________________________________ **DOB:**___________________________

ADDRESS: ____

____

PHONE: ______________________________ **COUNTY OF RESIDENCE**:____________

REFERRAL SOURCE: ____

REFERRAL SOURCE PHONE # ____

____

IS TREATMENT COURT ORDERED? ___________(If so, court order MUST be faxed to 606-298-2842 or emailed to Terri.Dotson@mtcomp.org prior to intake

PREGNANT YES NO **HIGH RISK**: YES NO

HOW FAR ALONG/PRENATAL CARE/DETOX:

____

____

DRUG HISTORY (INCLUDE NAME OF DRUG, AMOUNT USED & FREQUENCY)

____

____

LAST USE OF CHEMICALS (INCLUDE NAME OF DRUG/DATE LAST USED/AMOUNT USED)

____

____

IV DRUG USE: YES OR NO **DT'S/BLACKOUTS** YES OR NO

MEDICAL CONDITIONS (CURRENT CONDITIONS THAT MIGHT AFFECT DETOX AND TREATMENT):

____

____

MEDICATIONS AND DOSAGE:

____

____

(INFORM CLIENT THEY NEED TO HAVE A TWO WEEK SUPPLY ON ADMISSION AND IF THE MEDICATIONS THEY LISTED CAN BE BROUGHT TO TREATMENT OR NOT)

CURRENTLY ON MAT? YES NO **TYPE:** ______________________________

WHERE DO YOU RECEIVE MAT (Doctor/location)?

____

HEART PROBLEMS YES NO ____________________________________

DIABETES YES NO ____________________________________

BLEEDING ISSUES YES NO ____________________________________

TB SKIN TEST YES NO (Date of last test/request one be done) ______________

DEPENDENT CHILDREN: YES NO ____

AGE OF CHILDREN/WILL THEY BE COMING WITH YOU TO TREATMENT? (If yes, they must have **full, legal custody** and we ***MUST*** have current immunization records prior to intake)

____

____

LEGAL PROBLEMS (INCLUDE CURRENT LEGAL ISSUES & ALL COURT DATES IN THE NEXT 6 MONTHS)

____

____

CURRENT DUI'S YES NO **OFFENSE DATE**: ________________________

PROBATION/PAROLE YES NO **OFFICERS NAME**: ______________________

PREVIOUS TREATMENT (INCLUDE WHERE/WHEN AND WAS IT BENEFICIAL)

____

____

ASK ABOUT THE FOLLOWING

MCCC CLIENT YES NO **LAST APPOINTMENT DATE:**____________

COUNTY RECEIVING TREATMENT: ____

SUICIDE RISK YES NO **(If "yes" refer to crisis line: 1-800-422-1060**
EXPLAIN IF YES (INCLUDE DATES OF LAST THREATS OR ATTEMPTS AND HOW ARE THEY CURRENTLY) ____

____

DUAL DIAGNOSIS YES NO OTHER DX ____________________________________

SEIZURES YES NO DATE OF LAST ________________________________
MEDICATIONS________________________________

TYPE OF INSURANCE: ____

Notified of the following:

2 Week Supply of medications __________________
Personal Hygiene Products ______________________
Picture ID ___________________________________
Food Stamp Card ______________________________
Towels/Washcloths ____________________________
7 days' worth of clothing ________________
Proof of TB Skin Test __________________
Insurance Cards ______________________
WIC Card ____________________________
Medical Records if applicable (Proof of pregnancy, MAT, etc.___________________________________

IF IN REGION REFER TO OUTPATIENT IN COUNTIES ______________________
IF IN NEED OF DETOX GIVE DETOX NUMBERS
GIVE NUMBERS TO OTHER RESIDENTIAL FACILITES ___________ Alternate resources if not approved:

____

SIGNATURE OF PERSON TAKING REFERRAL:

____