CommWell Health Harvest House & Angelic House Residential Referral Form

Phone: (910) 567-7038 Fax: (910) 567-5022

Email: CWHResidentialReferral@commwellhealth.org Attention/Subject: Residential Referral

Please include any related and appropriate supporting documentation including but not limited to, an admission assessment, comprehensive clinical assessment, psychiatric evaluation, psychological testing, history & physical evaluation, all labs, medication list and discharge summary.

INITIAL SCREENING:

- Is patient active duty military? ☐ Yes ☐ No
- Is patient a veteran or eligible for care at a VA Medical Center? ☐ Yes ☐ No
- Is patient a registered sex offender? ☐ Yes ☐ No

If you answered **"Yes"** to *any* of the questions above, **STOP**, we cannot take a referral for this patient.

IDENTIFYING INFORMATION:

Client Name: _____ DOB: _____/_____/_____
Last First Middle

Address: _____
Street City State Zip Code County

Phone #('s): _____

Age: _____ SS #: _____-_____-_____ Gender: ☐ Male ☐ Female

Race: ☐ White, ☐ Black, ☐ Hispanic, ☐ Native American, ☐ Asian, ☐ Other: _____

Marital Status: ☐ Single, ☐ Married, ☐ Partnered, ☐ Divorced, ☐ Separated, ☐ Widowed

Emergency Contacts (Name, Relationship, Phone #'s, Address): _____

_____

_____

Insurance: ☐ IPRS/Indigent/Self-Pay ☐ Medicaid – Policy #: _____

☐ Medicare Policy #: _____ ☐ Private – must bring insurance card

Highest Grade Completed: _____

Reason for treatment:

What are your thoughts for wanting residential treatment? (Patient's words)"

_____

_____

What is going to be different? (Patient's words)"

_____

_____

What do you plan to do when you finish treatment? (Patient's words) _____

_____

_____

DSM V Classification: **Circle Severity for each disorder**

Primary: _____

◯ Mild (Presence of 2-3 symptoms) ◯ Moderate(Presence of 4-5 symptoms) ◯ Severe (Presence of 6 or more symptoms)

Secondary: _____

◯ Mild (Presence of 2-3 symptoms) ◯ Moderate(Presence of 4-5 symptoms) ◯ Severe (Presence of 6 or more symptoms)

Additional: _____

◯ Mild (Presence of 2-3 symptoms) ◯ Moderate(Presence of 4-5 symptoms) ◯ Severe (Presence of 6 or more symptoms)

Additional: _____

◯ Mild (Presence of 2-3 symptoms) ◯ Moderate(Presence of 4-5 symptoms) ◯ Severe (Presence of 6 or more symptoms)

ASAM Level:

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SUBSTANCE ABUSE: (note additional substance use on side if needed)

Substances Used	Last Used	How Much	How Often & Route	For How Long	Age of 1st Use

Active withdrawals from alcohol, benzo's, or opiates? ☐ No ☐ Yes, describe:_____

_____

Any IV Drug Use in the last 30 days? ☐ No ☐ Yes

History of withdrawals from alcohol, benzo's, or opiates? ☐ No ☐ Yes, describe:_____

_____

_____

Longest period of un-incarcerated abstinence & when: _____

_____

Describe conduciveness of patient's social support system & home environment to becoming sober and maintaining sobriety:_____

_____

_____

DSS Involvement: ☐ No ☐ Yes, describe:

SUBSTANCE ABUSE/MENTAL HEALTH / PSYCHIATRIC HISTORY:

Current Acute Symptoms: ☐ None ☐ Yes, describe:_____

_____

Outpatient Treatment (Provider, Dates Served, Services Received):_____

_____

_____

SAIOP or residential treatment history: _____

_____

Inpatient Treatment (Facility, Dates Served, Reason for Admission):_____

_____

_____

MEDICATION(S):

☐ See attached list. If no list, include dosage amount, schedule, how long taken, & compliance.

_____

_____

MEDICAL:

Current Conditions/Problems:_____

_____

_____

Allergies: ☐ NKDA ☐ Yes: _____

Seizure History: ☐ None ☐ Yes: _____

Able to perform all ADL's independently? ☐ Yes ☐ No, describe:_____

_____

Bowel - ☐ Continent ☐ Incontinent Bladder - ☐ Continent ☐ Incontinent

Assistive Devices - ☐ None ☐ Yes: _____

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LEGAL ISSUES:

Pending charges / Upcoming court dates: ☐ No ☐ Yes: _____

_____

Currently on Probation: ☐ No ☐ Yes – PO Name, Phone #, & County:_____

States lived in as adult other than NC:

TOBACCO CESSATION

Current tobacco use? ☐ Yes ☐ No

If yes, mark all the tobacco products used:

☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chewing Tobacco ☐ E-Cigarettes/Vapes ☐ Other: _____

If cigarettes are used, how many are smoked per day?

☐ < 10 cigarettes per day ☐ > 10 cigarettes per day

As of November 1st, 2022 CommWell Health residential treatment facilities will be tobacco free. CommWell Health is committed to assisting clients with smoking cessation and will provide education and treatment options. Clients must agree to comply with CommWell Health's tobacco free campus guidelines prior to admission. To confirm acknowledgement and understanding the client must sign below. Failure to comply with tobacco free guidelines may result in dismissal from the program.

I _____ _____ understand that as of November 1st, 2022 I will be unable to use tobacco products during the course of my treatment at CommWell Health. I agree to comply with the tobacco free guidelines set forth by CommWell Health.

Signature: _____ Date: _____

MEDICAL CLEARANCE & COVID-19 SAFETY MEASURES

All accepted residents must be medically cleared by a CWH medical provider. An appointment for medical clearance will be scheduled for the client within the first 24-hours of their arrival to the CWH treatment facility. Additionally, all Residential Intakes will receive a rapid COVID-19 Test as part of medical clearance. COVID-19 Testing results are preferred 24-48 hours prior to being transported to Harvest House & Angelic House from referral source.

If you are denied admission due to not receiving medical clearance, you will be transported to an alternate location of your choice within reason (no out-of-state transporting). Please print your name and initial that you have read this statement & identify an alternate location.

Name: _____ Initials: _____

Please identify a location below that you would like to be transported to if you do not receive medical clearance (Required prior to admission):

Address: _____ City: _____

Phone Number: _____

REFERRAL SOURCE:

Referrer Signature:_____ Date:_____

Agency Name:_____

Referrer Name, Credentials, & Title:_____

Phone:_____ Fax:_____

Email:_____

Address:

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RESIDENTIAL SERVICES USE ONLY:

Referral Received By:_____ Date Received: _____
Date(s) of Contact with Client: _____
Date Staffed: _____ Patient Accepted: ☐ Yes ☐ No, why:_____
Admission date_____

I, _____, certify that I searched for the patient identified above and found no matches on the NC Sex Offender Registry website on _____ (date).
Signature: _____

I, _____, certify that I searched for the patient identified above and found no matches on the National Sex Offender Registry website on _____ (date).
Signature: _____

I, _____, certify that I searched for the patient identified above and found no matches on the NC Court System calendar for pending court dates within the next 30-45 days _____ (date).
Signature: _____

Meets Criteria for Program : _____ Yes _____No

COMMENTS (if no please make comments):

Bed Date: _____

Staffing Date: _____

Staff Signatures:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____