

REFERRAL INTAKE FORM

Referral Agent _____

Date _____

Agency _____

Title _____

Address _____

City/State/Zip _____

Phone (_____) _____ Fax (_____) _____ E-mail _____

Demographic Information

Client Name: _____ WWC Client # _____

Date of Birth: _____ Age: _____ SSN: _____

Sex: Female Male

Trans-Gender Trans-Sexual : Male-to-Female Female-to-Male

("Trans-Gender" has *not* had gender reassignment surgery. "Trans-Sexual" *has* had gender reassignment surgery.)

Sexual Orientation: Heterosexual Gay Lesbian Bisexual

Unknown

Race/ Ethnic Origin: _____

Current Address: _____

Living Situation: _____

Are alcohol/drugs present/ prevalent in the current living situation?

Length of Time at Current Residence: _____

Previous Living Situation/Address:

Current Phone #: _____

Financial Information

Does Client Have An Income? Yes No

If Yes, detail the source(s) and amount(s):

Has client applied for any entitlements for which the application is pending? Yes No

If yes, give details:

If receiving Social Security disability benefits, does the client have a Representative Payee?

Yes No If yes, give name, phone # and relationship to client:

Referral Name: _____

Does Client Receive Any of the Following Entitlements/Benefits/Services? If so, indicate amount next to the relevant benefit.

Food Stamps Food Bank Services (where, frequency): _____

Unemployment Food & Friends (frequency): _____

Retirement WIC Other: _____

Does Client have Medicaid? Yes No If yes, give policy number: _____

Does Client Have Other Health Insurance? Yes No

If yes, provide name, policy number and phone number:

Does client's insurance cover substance abuse treatment? Yes No Unknown

Substance Abuse History

History of Drug Use (Indicate by number the Order of Choice.)

Substance Order of Choice _____

Date of First Use _____

Date of Last Use _____

Ave. Daily Amount Used _____

Route of Admission _____

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Inhalants |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> PCP | <input type="checkbox"/> Opiates |
| <input type="checkbox"/> Crack Cocaine | <input type="checkbox"/> LSD | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Other: _____ |

History of Detox Stays _____

Name of Detox Program: _____

Dates in Program Completed? Yes No

If didn't complete, reason why: _____

How Long Clean After Discharge? _____

Referral Name: _____

History of Substance Abuse Treatment

Name of Program _____

Type of Program: outpatient intensive day treatment residential methadone other

Dates in Program Completed? Yes No

If didn't complete, reason why: _____

How Long Clean After Discharge? _____

History of residency in Transitional Housing programs and Recovery Houses.

Name of Program _____

Type of Program: outpatient intensive day treatment residential methadone other

Dates in Program Completed? Yes No

If didn't complete, reason why: _____

How Long Clean After Discharge? _____

Does client have a sponsor? Yes No

Describe client's other supports:

Medical History

For all current medical problems/issues, provide the following information:

Health Problem Date First Diagnosed

Treatment

Receiving Treating Physician/Clinic

Physician/Clinic

Phone Number

If client has ever been hospitalized, provide the following information:

Referral Name: _____

Provide information regarding all prescription medications being taken:

Medication	Dose	Condition	Physician	Phone no.

List any over-the-counter medications taken:

Detail any surgeries client has had (what, when, where, etc.):

Detail any medical problems previously treated for, and current status:

Education History

Last grade *completed*: _____

If not a high school graduate, does client have a GED? Yes No

If no, has client ever taken GED courses? Yes No

List any higher education/ degrees achieved: _____

Employment History

Last job held (job title, dates of employment, employer name, reason for leaving):

List job skills: _____

Longest job held: _____

Referral Name: _____

Mental Health History

Please provide the following information:

Psychiatric Diagnosis

Date First Diagnosed

Medication Prescribed

Treating Clinician

Clinician's Phone Number

Has client experienced suicidal ideation in past or made suicide attempts? Yes No

If yes, please provide date(s) and details of the occurrence(s):

Past history of violence? Yes No

If yes, please provide date(s) and details of the occurrence(s):

Section B:

(To be completed by primary care physician)

_____ has applied to Whitman Walker Clinic's
(Referral name) (Date of birth)

Bridge Back Program for residential drug treatment.

Are you the referral's primary care physician? Yes No

For how long: _____ Date of Next Appointment: _____

HIV/ AIDS Status

1. Does the referral have HIV or AIDS? Yes No

Other Medical Problems

1. What are the referral's current medical problems?

2. What are the current medications the referral is taking?

Medication	Dose	How Administered
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Is referral able to self-administer all medications? Yes No

TB Status

Please include a copy of the referrals test results or x-ray

1. In addition to a general physical health examination, the following required tests have been done:

Tuberculin Test (Check One) _____ Tine _____ PPD

Date: _____ Result: _____ Signed: _____

Chest X-Ray: Date: _____ Result: _____ Signed: _____

Referral Name: _____

Medical Stability

1. Do you feel the referral is medically stable enough to actively participate in The Bridge Back Program? This includes attending therapy groups, fixing meals, engaging in housekeeping activities, performing light exercising, attending outside meetings and community outings.

Yes No

Primary Care Physician Information

Physician Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

Emergency Phone Number _____

Signature of Physician

Date