

CommWell Health BHS Residential Services Referral Form

Phone: (910) 567-5020 Fax: (910) 567-5022

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

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:

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

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

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

Any IVDU in the last 30 days? No Yes

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

Longest period of unincarcerated 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: _____

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: _____

REFERRAL SOURCE:

Referrer Signature: _____ Date: _____

Agency Name: _____

Referrer Name, Credentials, & Title: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

