

**RESIDENTIAL PROGRAM REFERRAL**

***PLEASE PRINT***

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| **CLIENT INFORMATION:**  |
| Client Name:  |
| Race:  | Age: | Gender Preference:  |
| Address:  | Phone Number:  |
| County of Residence:  | Date of Birth:  | Last 4 Digits of SS#: XXX-XX-\_\_\_\_\_\_\_\_ |
| Emergency Contact:  | Contact Number:  | Alternative Number:  |
| Referring Agency:  | Contact Person:  | Agency Phone: |
| Is the client currently experiencing withdrawal? [ ]  Yes [ ]  No |
| Does the client require accommodations? [ ]  Yes [ ]  No If yes please specify: TTY [ ]  Interpreter [ ]  Sign language  [ ]  Ambulatory limitations [ ]  Other |
| **SUBSTANCE ABUSE HISTORY****WHICH OF THE FOLLOWING HAVE THE INDIVIDUAL USED IN THE LAST 30 DAYS?**  |
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|  |  |  |  |  |  |  |  |
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| **Substance** | **Amount****Per Day** | **How long has client been using** | **Date of Last Use** | **Substance** | **Amount****Per Day** | **How long has client been using** | **Date of Last Use** |
| Alcohol  |  |  |  | Heroin  |  |  |  |
| Barbiturates |  |  |  | Other Opiates |  |  |  |
| Marijuana/Weed |  |  |  | Benzodiazepines |  |  |  |
| Cocaine (Crack |  |  |  | Fentanyl |  |  |  |
| Hallucinogens  |  |  |  | Buprenorphine |  |  |  |
| Methamphetamines |  |  |  | Other  |  |  |  |

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| **INSURANCE: PLEASE SUBMIT A COPY OF THE INSURANCE CARD WITH THE REFERRAL** |
| Does the client currently have insurance? [ ] Yes [ ]  No  |
| If yes, please list the company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| MA #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **UNINSURED APPLICANTS:** *PROOF OF INCOME IS REQUIRED FOR:* * All uninsured individuals and Medicare recipients who do not also have Medicaid
* Determination of eligibility for a reduction in payment for services rendered utilizing the state of Maryland or Federal sliding fee scale and other state funding sources

If proof of income is not provided at the time of admission, clients will be charged 100% per day  |

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| **LEGAL STATUS**  |
| Are you currently on parole or probation? [ ] Yes [ ]  No  | Is there a current warrant? [ ] Yes [ ]  No  |
| Name of Probation or Parole Officer:  | Phone Number:  |
| Court Date Pending? [ ] Yes [ ]  No  | Court Date:  |
| Charges:  |

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| **MEDICAL STATUS** |
| Is the client medically stable? [ ]  Yes [ ]  No  |
| Current Medications | Dose/Frequency  | How long on Meds?  | Current Medications | Dose/Frequency | How long on Meds?  |
|  |  |  | 5.  |  |  |
|  |  |  | 6.  |  |  |
|  |  |  | 7.  |  |  |
|  |  |  | 8.  |  |  |
| **MEDICAL PROBLEMS, RECENT ILLNESS OR INJURIES** |
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|  |  |
| **ALLERGIES**  |
| **PLEASE LIST ALL ALLERGIES** |
| **PPD SCREENING**  |
| History of +PPD [ ]  Yes [ ]  No If yes, client must has a x-ray prior to admission.  |

**FAILURE TO COMPLETE THE REQUESTED REFERRAL INFORMATION COULD RESULT IN A DELAY OR DENIAL OF ADMISSION TO THE PROGRAM**

**I agree that the above information is accurate and complete. Misrepresentation of the information provided on this form may result in the denial of admission.**

**Service Recipient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **DISCLOSURE AUTHORIZATION FORM** |

I agree to this referral and authorization. In an event I cannot be reached or additional information is needed, I authorize other service providers or organizations listed on this referral be contacted on my behalf for the purpose of coordinating this referral.

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| Print NameService Participant Signature |    | Date \_\_\_\_\_ |
| Print NameGuardian Signature |    | Date \_\_\_\_\_ |

Referral Source Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_