Standardized Residential Services Referral Form*

*(In lieu of Catalyst Client Information and Admission Information screens)

Client # _____ (Res. facility use only) Referral Date: d_____/m_____/y_____ (Res. facility use only)

Client Name: _____ , _____DOB:____/____/____ Age: ____
Last First

Street Address: _____ City: _____

Postal Code (if NFA, list a P.C. for current county): _____ County: _____

Home Phone: ( ) _____ □ phone call allowed □ message allowed

Alt. Number: ( ) _____ □ phone call allowed □ message allowed

Emergency Contact: _____ Phone # ( ) _____

Referral Information

Referral Date: d____/m____/y____ Type of Service: ☐ Comm. Tx. &/or A/R Services or ☐ WMS/Detox

Referral Agency: _____ Contact Name: _____

Phone Number: ( ) _____ Ext: _____ Fax Number: ( ) _____

Treatment Mandated/Required by: _____ Legal Status: _____

Pending Legal Charges: ☐No ☐Yes, _____ Court Date: _____

Relationship Status: _____ Employment Status: _____

Level of Education: _____ Source of Income: _____

Presenting Issues at Admission: ☐ Alcohol ☐ Drugs _____ ☐ Gambling

Presenting Problem Substances

	Substance	Frequency Used in Past 30 Days
1st	_____	_____
2nd	_____	_____
3rd	_____	_____

Substances Used in the Past 12 Months:_____

_____

Problem Gambling Identified: Y N Gambling activities engaged in the past 12 months: _____

_____

Health Status/Problems: Check all that apply

☐ Vision ☐ Hearing ☐ Mobility ☐ Non-medical IV drug use, if yes last use: _____

☐ Number of overnight hospitalizations in the past 12 months for physical health problems: _____

Reason(s) for hospitalization: _____

Diagnosed with a mental health problem by a qualified mental health professional? ☐ No ☐ Yes,

☐ Within the last 12 months ☐ Within a lifetime

Most recent diagnosis # 1: _____

Most recent diagnosis # 2: _____

Hospitalized for a mental health problem? ☐ No ☐ Yes,

☐ Within the last 12 months ☐ Within a lifetime

Received treatment for a mental health, emotional, behavioral, or psychological problem from community mental health program/professional? ☐ No ☐ Yes,

☐ Currently ☐ Within the last 12 months ☐ Within a lifetime

Name of service provider: _____

Contact information: _____

Prescribed medication for a mental health problem: ☐ No ☐ Yes,

☐ Currently ☐ Within the last 12 months ☐ Within a lifetime

Health concerns: (check all that apply)

□ allergies	□ blood pressure problems	□ cancer
□ chronic pain	□ diabetes	□ eating disorder
□ HIV/AIDS	□ heart disease	□ Hepatitis A
□ hepatitis B	□ Hepatitis C	□ history of head injuries
□ history of seizures	□ history of seizures/epilepsy	□ jaundice
□ kidney disease	□ lice/scabies	□ liver disease
□ respiratory problems	□ sexually transmitted illness	
□ stomach/gastrointestinal problems	□ tuberculosis	

Drugs Currently Prescribed:

List ALL (prescribed & OTC) medication by classification (e.g. antidepressant, diuretic) currently being used by the client:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____