

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
1 st _____	_____
2 nd _____	_____
3 rd _____	_____

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)

- | | | |
|--|---|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> blood pressure problems | <input type="checkbox"/> cancer |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> diabetes | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> heart disease | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> history of head injuries |
| <input type="checkbox"/> history of seizures | <input type="checkbox"/> history of seizures/epilepsy | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> lice/scabies | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> respiratory problems | <input type="checkbox"/> sexually transmitted illness | |
| <input type="checkbox"/> stomach/gastrointestinal problems | <input type="checkbox"/> tuberculosis | |

Drugs Currently Prescribed:

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

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____