



Fora Health Residential Referral Form

Must be completed for all referrals

General Information

- ▶ If available, please fax/email a drug & alcohol ASAM assessment, medication list and medical/mental health records along with this Referral Packet.
- ▶ Fax this Referral Packet and any additional information requested below to the attention of Admissions: (503) 535-1163.
- ▶ For questions about this referral, including whether or not it has been received, please email referrals@forahealth.org.
- ▶ Hospital referrals must also have medical records faxed with the packet and a discharge medication list at least 24 hours in advance of appointment.
- ▶ Fora Health is a tobacco-free facility. Smoking, chewing tobacco, vaping and other related products are not permitted. Smoking cessation services and adjunctive therapy through prescription of Nicotine Replacement Therapy are available based on an individual's needs.
- ▶ We do not allow most controlled substances or sedatives in our facility: benzos, Flexeril, tramadol, diphenhydramine, Sudafed, ambien, stimulants, barbituates. Please contact admissions for more information about policies regarding buprenorphine/naloxone.
- ▶ Patients must arrive with a 14 day physical supply of all prescribed medication in the original pharmacy container with a valid, current label from their current medication list.
- ▶ Appointments that require leaving our facility are discouraged for the first 30 days of treatment.
- ▶ Please review our website for personal items/clothing to bring for residential. We do not have storage for any additional items.
- ▶ We will contact you if additional information if needed, otherwise your referral will be put on our waitlist and you will be contacted when a bed is becoming available.

Referring Provider/Agency Information

- ▶ In order for us to confirm patient admission status, please complete the ROI beginning on the next page including type of information to be shared.

Name of Referring Hospital/Facility/Agency including Department/Team Name:	
Name of Contact Person Making Referral:	Phone:
Estimated Hospital/Facility Discharge Date:	
Notes:	



Adult Residential Engagement Form

Initial Screening

Has the patient been charged with a sex offense? Yes No

Do you need assistance performing normal activities of daily living (toileting, medication administration, showering)? Yes No

If you answered "Yes" to any of the questions above, **STOP**, we cannot take a referral for this patient

General Information

Date: _____ SSN: _____ Insurance: _____

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____ Contact number: _____

Gender: Female Male Trans Female/Trans Woman/Affirmed Woman
 Genderqueer/Gender Non-Conforming Trans Male/Trans Man/Affirmed Man
 Agender/Without Gender Declined Additional Category: _____

What are your reasons for wanting residential treatment? _____

What is going to be different for you if you go to residential? _____

What do you plan to do when you finish treatment? _____

Drug(s) of Choice: _____ Method of use: _____

Date of last use: _____ What's the longest you were sober in the last year: _____

How many days per week do you usually use: _____

Alcohol: _____ out of 7 days Benzodiazepines: _____ out of 7 days

Opioids: _____ out of 7 days Meth/Amphetamines: _____ out of 7 days

Other: _____ out of 7 days Any IVDU is last 30 days? Yes No

Do you have active withdrawals from alcohol, opiates or benzos? Yes No

Do you know anyone working at Fora Health or any other patients here? _____

Will you or your family need interpretive services Yes No Specify: _____
(language, hearing, other)? _____

Emergency Contact

Name: _____

Address: _____

Telephone: Home: _____ Cell: _____

Relationship: _____



Medical Information

Do you take or are you supposed to take prescription medications? Yes No *if yes, list:*

Medication Name and Indication	

To ensure that we provide you with the most appropriate care, please let us know if you:

Have had a psychiatric hospitalization in the last 6 months? Yes No

Have had more than three visits to the ER in the last 6 months? Yes No

Have a diagnosis of HIV or Hepatitis C? Yes No

Use medications that require an injection? Yes No

Must be seen by outside medical providers during first few months of treatment? Yes No

Have difficulties with ambulation? Yes No

Have a seizure disorder? Yes No

Are you pregnant? Yes No If yes, when is your due date? _____

Allergies? Yes No *if yes, please list out allergies:* _____

Please describe any special medical/dietary concerns:



Mental Health Information

Do you have any mental health issues or concerns?

- Anxiety
- Depression
- Schizophrenia
- Other: _____
- Bipolar Disorder
- Psychosis
- Trauma
- Borderline Personality Disorder
- PTSD
- Schizoaffective Disorder

Have you had suicidal thoughts in the past 12 months? Yes No

Have you been hospitalized for suicidal thoughts? Yes No *if yes, when?* _____

Suicide attempts? Yes No *if yes, when?* _____

Do you harm yourself or cut yourself now or in the past? Yes No

if yes, please describe: _____

Have you recently had homicidal thoughts? Yes No

Legal Information

Are you currently incarcerated? Yes No

Do you have any pending charges/Upcoming Court Dates? Yes No

if yes, please describe: _____

Parole/Probation

Officer name: _____ **County:** _____

Parole/Probation Officer phone: _____

Do you have recent or past involvement of any of the following?

Please provide the charge(s) and date(s) if applicable.

Animal Abuse: No Yes: _____

Assault: No Yes: _____

Fire Starting: No Yes: _____

Gang Involvement: No Yes: _____

Sex Offenses: No Yes: _____

Other: No Yes: _____

Does anyone have a restraining order against you or you against them?

Yes No *if yes, who?* _____

Are there any no contact order(s) in place for anyone?

Yes No *if yes, with who?* _____