Fora Health
PO Box 16040
Portland, OR 97292
Main (503) 535-1151
Email referrals@forahealth.org

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:	

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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 (language, hearing, other)? ☐ Yes ☐ No Specify: _____

Emergency Contact

Name: _____

Address: _____

Telephone: Home: _____ **Cell:** _____

Relationship: _____

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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:

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Mental Health Information

Do you have any mental health issues or concerns?

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

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? _____