

## 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](mailto: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.

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

## 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?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Borderline Personality Disorder |
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Psychosis        | <input type="checkbox"/> PTSD                            |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Trauma           | <input type="checkbox"/> Schizoaffective Disorder        |
| <input type="checkbox"/> 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?* \_\_\_\_\_