

Fora Health Residential Referral Packet

General Information

- ▶ If available, please fax a drug & alcohol ASAM assessment and medical/mental health records along with this Referral Packet. This will make placement on the waitlist and admission to residential much quicker.
- ▶ Fax this Referral Packet and any additional information requested below to the attention of Kellie Fellen, Admissions Supervisor: (503) 535-1163.
- ▶ **All referrals require the patient to complete an Adult Residential Engagement form from this packet.**
- ▶ 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 Kellie Fellen for more information about policies regarding buprenorphine/naloxone.
- ▶ Patients must arrive with a physical supply of all prescribed medication in the original pharmacy container with a valid, current label from their current medication list.
- ▶ 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 after receiving the required forms and records. You must speak with an intake specialist to confirm appointment availability.
- ▶ Any questions please call Kellie Fellen at (503) 535-1164.

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

Residential patients are required to go up and down three flights of stairs several times a day for groups and classes. Is this something that will be an issue for you? 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: _____

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 reason 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

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

Any IVDU is last 30 days? 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	

Do you have or ever had any of the following? Please specify next to the box.

- Heart Disease Arthritis Migraines Stroke
- Lightheadedness Diabetes Tuberculosis Hernia
- Cancer Ulcers High Blood pressure Liver Disease
- Abscesses Head Injury Shortness of Breath Kidney or Thyroid Disease
- HIV Hepatitis Lung Disease (COPD, Asthma, Emphysema, Bronchitis)
- Other: _____

Seizures? Yes No *if yes, what was the date of your last seizure:* _____

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

Are you pregnant? Yes No N/A (male) *if yes, what is your due date:* _____

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

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?* _____