

A. F. WHITSITT CENTER REFERRAL CONTACT FORM

Fax 410-778-7002

Please complete all four (4) referral pages.

DATE RECEIVED: (WHITSITT USE ONLY)							
IDENTIFICATION SECTION:				Please Print			
PATIENT NAME: LAST			FIRST		MIDDLE		
RACE:	AGE:	SEX:	PATIENT'S HOME PHONE:			DATE:	
ADDRESS:				CITY, STATE, ZIP:			
SOCIAL SECURITY NUMBER:			DATE OF BIRTH:		COUNTY OF RESIDENCE:		
EMERGENCY CONTACT			CONTACT NUMBER		ALTERNATIVE NUMBERS		
REFERRING AGENCY:			CONTACT PERSON:		AGENCY PHONE NUMBER:		
(Circle One)		DETOX REFERRAL			ICF REFERRAL		
SUBSTANCE ABUSE HISTORY							
Which of the following substances have you used in the past 30 days?							
Substance	Amount used per day	How long has pt been using	Date of last use	Substance	Amount used per day	How long has pt been using	Date of last use
Alcohol				Heroin			
Barbiturates				Methadone			
Cannabis/Pot				Other Opiates			
Cocaine				Benzodiazepines			
Hallucinogens				Other			

DSM-V Diagnostic Codes for Substance –Use Disorders

	Dependence	Abuse		Dependence	Abuse
Alcohol	F10.20	F10.10	Nicotine	F17.20	F17.10
Amphetamines	F15.20	F15.10	Opioids	F11.20	F11.10
Cannabis	F12.20	F12.10	Phencyclidine	F19.20	F19.10
Cocaine	F14.20	F14.10	Sedatives, etc.	F13.20	F13.10
Hallucinogens	F16.20	F16.10	Other/Unknown		
Inhalants	F18.20	F18.10			

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

INSURANCE: PLEASE SUBMIT COPY OF INSURANCE CARD WITH REFERRAL

DOES THIS PATIENT HAVE HEALTH INSURANCE? YES NO

IF YES, COMPANY: _____

POLICY #: _____

PRECERTIFICATION DATE: _____

NAME OF REPRESENTATIVE CONTACTED: _____

LENGTH/TYPE OF TREATMENT AUTHORIZED: _____

UNINSURED APPLICANTS:

PROOF OF INCOME IS REQUIRED FOR:

- all uninsured individuals and all Medicare recipients who do not also have Medicaid.
- determination of eligibility for a reduction in payment for services rendered utilizing the State of Maryland sliding fee scale and other state funding sources.

If proof of income is not provided at time of admission, patients will be charged 100% per day

LEGAL STATUS:

PROBATION/PAROLE	YES	NO	WARRANT	YES	NO
COURT DATE PENDING	YES	NO	COURT DATE	_____	

CHARGES:

ARRANGEMENTS FOR PENDING COURT DATES SHOULD BE HANDLED PRIOR TO ADMISSION**PSYCHIATRIC STATUS:**

	Within the past month	Within the past year
1. SUICIDAL THOUGHTS/ATTEMPTS	YES NO	YES NO
2. THOUGHTS OF SELF MUTILATION (ACTS)	YES NO	YES NO
3. HOMICIDAL THOUGHTS/ATTEMPTS	YES NO	YES NO
4. HALLUCINATIONS AUDITORY VISUAL TACTILE	YES NO	YES NO

If the answer is yes to any of the above, please explain with detailed information. Patient reports he had suicidal thoughts but did not have any desire to follow through or a plan, just felt depressed with his life due to drugs.

Is patient psychiatrically stable to participate in treatment and follow all the rules and regulations of the Whitsitt Center.	YES NO
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PREVIOUS PSYCHIATRIC TREATMENT		WHEN:			
PSYCH MEDS TAKEN		WHERE:			
1.		DIAGNOSIS:			
2.		DIAGNOSIS:			
3.		PSYCHIATRIST:			
MEDICAL STATUS: Please bring current medications					
Is the patient medically stable? YES NO					
Current Medications	Dose Frequency	How long on meds	Current Medications	Dose Frequency	How long on med
1.			4.		
2.			5.		
3.			6.		
MEDICAL PROBLEMS, RECENT ILLNESSES OR INJURIES:					
1.		2.			
3.		4.			
ALLERGIES:					
List all Allergies: _____					
PPD SCREENING:					
History of +PPD Yes ___ No X					
If yes, Patient must have x ray prior to admission.					
ADVANCE DIRECTIVE / MARYLAND MOLST FORM					
Does the patient have an Advance Directive?				YES	NO
Does the patient have a Maryland MOLST Form (Medical Orders for Life-Sustaining Treatment)				YES	NO
Please bring copies at admission					

**FAILURE TO COMPLETE REQUESTED REFERRAL INFORMATION COULD
RESULT IN A DELAY OR DENIAL OF ADMISSION.**

I agree that the above information is accurate and complete. Misrepresentation of the information provided on this form may result in denial of admission.

PATIENT SIGNATURE/DATE:

ASAM ADMISSION CRITERIA

	LEVEL 1 (1-8 HRS/WK)	LEVEL 2 (9-56+HRS/WK)	LEVEL 3&4 (24HRS/DAYS)
WITHDRAWAL POTENTIAL	<input type="checkbox"/> Minimal risk of severe withdrawal	<input type="checkbox"/> Minimal risk of severe withdrawal	<input type="checkbox"/> Severe withdrawal risk
BIOMEDICAL CONDITIONS	<input type="checkbox"/> None or very stable	<input type="checkbox"/> Will not interfere with treatment; <u>or</u> <input type="checkbox"/> Can be provided in outpatient treatment	<input type="checkbox"/> Continued use jeopardizes physical health for concomitant biomedical conditions; <u>or</u> <input type="checkbox"/> Requires medical monitoring or management
EMOTIONAL	<input type="checkbox"/> None or very stable(Not manifesting stress behavior or instability); <u>and/or</u> <input type="checkbox"/> Anxiety, guilt, depression is related to use problems; if not Psych services are provided; <u>and</u> <input type="checkbox"/> No risk harming self or others	<input type="checkbox"/> Mild severity, with potential to distract from recovery (unstable over 72 hr period, e.g., distractibility, negative emotions, generalized anxiety); needs monitoring; <u>or</u> <input type="checkbox"/> Addiction related abuse/negative of family; <u>or</u> <input type="checkbox"/> Mild risk of endangering self or others, (thoughts of but no active plans); <u>or</u> <input type="checkbox"/> Stable disorder that requires monitoring or management (Can spontaneously describe methods to cope with mental disorder and demonstrates resolve to focus on addictions treatment) <input type="checkbox"/> PHP: needs stabilization	<input type="checkbox"/> Emotional/behavioral symptoms necessitate 24-hr structured environment to allow focus on recovery or to shape behavior; <u>or</u> <input type="checkbox"/> Current suicidal/homicidal thoughts with no active plan and a history of gestures or threats; <u>or</u> <input type="checkbox"/> Manifesting stress behaviors related to losses to extent activities of daily living are impaired; <u>or</u> <input type="checkbox"/> History or presence of violent or disruptive behavior during intoxication with imminent danger to self or others; <u>or</u> <input type="checkbox"/> Personality disorder requiring continuous boundary setting interventions.
TREATMENT ACCEPTANCE RESISTANCE	<input type="checkbox"/> Expresses willingness to cooperate with the treatment plan and the attend all scheduled activities; <u>and</u> <input type="checkbox"/> Needs motivating and monitoring strategies but does not need structured milieu.	<input type="checkbox"/> Resistance high enough to require structured program, but not so high as to render out-patient treatment ineffective (willing to participate in most respects but may have reservations; e.g. does not offer any benefit from treatment, strong objections to frequency of groups, motivation is to avoid jail); <u>or</u> <input type="checkbox"/> Failure of motivating interventions at different levels of care; <u>or</u> <input type="checkbox"/> Attributes drug problems to externals (unable to elaborate on the relationship of life problems to alcohol/drug abuse in a specific and detailed manner).	<input type="checkbox"/> Despite serious consequences or effects of the addictions, client does not accept or relate to the severity of these problems; <u>or</u> <input type="checkbox"/> Marked difficulty with or opposition to treatment, does not appear to be committed to seeking treatment, and requires intensive motivating strategies available only in a 24-hr structured environment.
RELAPSE POTENTIAL	<input type="checkbox"/> Able to maintain abstinence and pursue recovery goals with minimal support; needs assistance in dealing with mental preoccupation with using, craving, peer pressure, lifestyle and attitude changes; <u>and</u> <input type="checkbox"/> Is not experiencing difficulty postponing immediate gratification or related drug-seeking behavior, <u>and</u> <input type="checkbox"/> Has some awareness of triggers.	<input type="checkbox"/> High likelihood of use with close monitoring and support, as indicated by lack of awareness of triggers, difficulty postponing immediate gratification or ambivalence/ resistance to treatment; <u>or</u> <input type="checkbox"/> Despite active participation at a less intensive level, client is experiencing an intensification of addiction symptoms(e.g. difficulty postponing immediate gratification or related drug-seeking behavior) and is deteriorating in functioning despite revisions in the treatment plan.	<input type="checkbox"/> Despite active participation at a less intensive level or self-help fellowship client is experiencing an acute crisis with a concomitant intensification of addiction symptoms; <u>or</u> <input type="checkbox"/> Recognizes that alcohol and/or other drug use is excessive and has been unable to do so as long as alcohol/other drugs are present in his environment.
SUPPORT/ RECOVERY ENVIRONMENT	<input type="checkbox"/> Supportive recovery environment (s/o's are in agreement with recovery efforts, supportive work or legal conviction adequate transportation, support meetings are accessible); <u>or</u> <input type="checkbox"/> Lacks ideal support system but is sufficiently stable and has demonstrated motivation and willingness to obtain support system; <u>or</u> <input type="checkbox"/> S/o's are supportive but require 'professional interventions to improve chances of treatment success (e.g. assistance in limit-setting, communication skills, decrease rescuing behaviors, etc).	<input type="checkbox"/> Those living with the client are unsupportive of recovery goals and/or passively opposed to his treatment, no active opposition, and client requires relief from home environment far part of the day to stay focused on recovery; <u>or</u> <input type="checkbox"/> Continued exposure to the current job environment will make recovery unlikely; <u>or</u> <input type="checkbox"/> Lack of social contacts which jeopardizes recovery	<input type="checkbox"/> Lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g. chaotic family or interpersonal conflicts which undermine clients efforts to change, s/o's manifest current substance use, s/o's undermine the client's recovery); <u>or</u> <input type="checkbox"/> Logistic impediments; <u>or</u> <input type="checkbox"/> Danger of physical, sexual, or severe attack or victimization; <u>or</u> <input type="checkbox"/> Engaged in an occupation where continued use constitutes imminent risk to public or personal safety

COMPLETED BY _____

DATE _____

