

John L Norris Addiction Treatment Center

1111 ELMWOOD AVENUE ROCHESTER, NY 14620

(585) 461-0410

FAX (585) 461-1602

REFERRAL FOR INPATIENT SERVICES FORM

DATE	REFERRAL AGENCY NAME	STAFF CONTACT	ADDRESS	TELEPHONE NUMBER
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Patient Name:		Maiden Name/AKA:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:		City:		State:	Zip Code:
County:		Telephone Number:		Date of Birth:	
Message Phone Number (must be completed)		Social Security No		Medicaid Number	

Insurance Company and ID #		Is patient an ARES client? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date referral sent to Monroe Plan: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Unknown	
If no insurance, has DSS application been initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Appointment Date:	
Is there an inpatient rider? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, has precertification been obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pre Certification Number:			

Circumstances leading to referral for Inpatient Treatment:

Is patient a member of any of the following groups? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Pregnant Woman Due Date	Primary Language:
<input type="checkbox"/> Veteran <input type="checkbox"/> Drug Court	<input type="checkbox"/> English <input type="checkbox"/> Spanish
<input type="checkbox"/> Native American <input type="checkbox"/> Under Age 19	<input type="checkbox"/> ASL <input type="checkbox"/> Other (specify)
<input type="checkbox"/> Hispanic <input type="checkbox"/> Current Legal Problems	

Current Use Report

Substance	Amount	Frequency of Use	Last Date of Use
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Cocaine			
<input type="checkbox"/> Marijuana			
<input type="checkbox"/> Heroin			

Assigned Diagnostic Codes – Check All That Apply

Substance	Abuse	Dependence	Substance	Abuse	Dependence
<input type="checkbox"/> Alcohol	<input type="checkbox"/> 305.00	<input type="checkbox"/> 303.90	<input type="checkbox"/> Amphetamine	<input type="checkbox"/> 305.70	<input type="checkbox"/> 304.40
<input type="checkbox"/> Cocaine	<input type="checkbox"/> 305.60	<input type="checkbox"/> 304.20	<input type="checkbox"/> Sedative	<input type="checkbox"/> 305.40	<input type="checkbox"/> 304.10
<input type="checkbox"/> Marijuana	<input type="checkbox"/> 305.20	<input type="checkbox"/> 304.30	<input type="checkbox"/> Poly-Drug	<input type="checkbox"/> 305.90	<input type="checkbox"/> 304.80
<input type="checkbox"/> Heroin	<input type="checkbox"/> 305.50	<input type="checkbox"/> 304.00	<input type="checkbox"/> Nicotine		<input type="checkbox"/> 305.10

Comments/Other Diagnostic Impressions/Referral Recommendations:

Reason for Admission as Stated by Patient:

Previous Treatment for Alcoholism/Substance Abuse

Type of Treatment (please check)			Name of Facility	Dates of Treatment		Completed
I/P Res	O/P	Detox		From	To	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No

Current Medication History

Current medication history (medication name, dosage, frequency and indication):

Past medication history (if available):

Any known drug allergies? Yes No If yes please specify:

Active Medical Problems:

Current Medical Provider (PCP):

Does patient have any physical limitations? Yes No

If yes, describe:

Last PPD: Results: Any Tx:

Is there a history of seizures (including during withdrawal)? Yes No If yes describe:

Current/Previous Psychiatric History

Current Psychiatric Concerns:

Please answer the following specific questions

- Has this person ever attempted suicide? Yes No
- If yes, were they under the influence of any substance? Yes No
- Has this person ever experienced homicidal behaviors? Yes No
- If yes, were they under the influence of any substance? Yes No
- Has this person ever experienced any psychotic symptoms (hallucinations, paranoia, thought disturbances)? Yes No
- If yes, were they under the influence of any substance? Yes No
- Has this person ever had a Mental Hygiene Arrest? Yes No
- If yes, were they under the influence of any substance? Yes No
- Has this person been admitted to the Psychiatric Emergency Room/Hospital in the last 3 months? Yes No
- If yes, were they under the influence of any substance? Yes No

*****IF THE ANSWER FOR ANY OF THE ABOVE IS YES, PLEASE ELABORATE ON A SEPARATE SHEET OF PAPER AND INCLUDE MEDICAL RECORDS FROM FACILITIES (IF RECENT). *****

Previous Psychiatric Treatment/Including Childhood

Diagnoses & Conditions	Name of Facility	Dates

Current/Previous Legal Issues:

Is patient on Parole? Yes No

Is patient on Probation? Yes No

*****If yes to either above, please include PSI evaluation*****

Is patient involved with ATI? Yes No

Parole/Probation/Drug Court Case Manager/ATI worker's name and telephone number below:

*****If patient is incarcerated currently, please include Correctional Medical Services Records (CMS), including mediations and dosages received while incarcerated*****

Does patient have a Sexual Offender Status or current charges? Yes No

If so, what level Sex Offender?

Signature:

Date: