John L Norris Addiction Treatment Center

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(585) 461-0410
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Referral for Inpatient Services Form

DATE	REFERRAL AGENCY NAME	STAFF CONTACT	ADDRESS	TELEPHONE NUMBER

Patient Name:	Maiden Name/AKA:	Sex: ☐ Male ☐ 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? ☐ Yes ☐ No Date referral sent to Monroe Plan: ☐ Approved ☐ Denied ☐ Unknown
If no insurance, has DSS application been initiated? ☐ Yes ☐ No	Appointment Date:
Is there an inpatient rider? ☐ Yes ☐ No	If yes, has precertification been obtained? ☐ Yes ☐ No Pre Certification Number:

Circumstances leading to referral for Inpatient Treatment:

Is patient a member of any of the following groups? ☐ Yes ☐ No

☐ Pregnant Woman	Due Date	Primary Language:
☐ Veteran	☐ Drug Court	☐ English ☐ Spanish
☐ Native American	☐ Under Age 19	☐ ASL ☐ Other (specify)
☐ Hispanic	☐ Current Legal Problems	

Current Use Report

Substance	Amount	Frequency of Use	Last Date of Use
☐ Alcohol			
☐ Cocaine			
☐ Marijuana			
☐ Heroin			

Assigned Diagnostic Codes – Check All That Apply

Substance	Abuse	Dependence	Substance	Abuse	Dependence
☐ Alcohol	☐ 305.00	☐ 303.90	☐ Amphetamine	☐ 305.70	☐ 304.40
☐ Cocaine	☐ 305.60	☐ 304.20	☐ Sedative	☐ 305.40	☐ 304.10
☐ Marijuana	☐ 305.20	☐ 304.30	☐ Poly-Drug	☐ 305.90	☐ 304.80
☐ Heroin	☐ 305.50	☐ 304.00	☐ Nicotine		☐ 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	
☐	☐	☐				☐ Yes ☐ No
☐	☐	☐				☐ Yes ☐ No
☐	☐	☐				☐ Yes ☐ No
☐	☐	☐				☐ Yes ☐ 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: