McLean at Naukeag Ambulatory Treatment Center Self-Referral Packet

NOTE: ***To be considered for admission application must be complete in full (If you need assistance with the application call 978-827-5115 ask for admissions***

How did you hear about Naukeag: _____

PATIENT INFORMATION

DATE: ----------

Have you been to Naukeag previously? ☐ Yes ☐ No

Are you being referred by any program or treatment provider? ☐ N ☐ Y (name): _____

Patient Name: _____ Age_____ Gender: _____ DOB: _____

Address: _____ State/Country: _____ ZIP: _____

Email: _____ Daytime phone #:_____Cell #: _____

Preferred method of contact: ☐ Email ☐ Phone ☐ Cell ☐ All Best time:_____

PRESENTING PROBLEM: Check all boxes that describe issues you are currently dealing with:

☐ alcohol problem ☐ drug problem ☐ depression ☐ anxiety ☐ trauma issues ☐ suicidal ideation

☐ eating disorder ☐ relationship conflict ☐ housing/homelessness ☐ anger management ☐ ADD

☐ work issues ☐ school issues ☐ grief issues

Briefly state why you are considering admission to Naukeag at this time:

_____

_____

_____

_____

_____

_____

CURRENT TREATMENT

Do you have current treatment providers? ☐ Y ☐ N Do you have a psychiatric diagnosis? _____

Name/Agency_____ therapist, psychiatrist, IOP, partial Phone: _____

Name/Agency_____ therapist, psychiatrist, IOP, partial Phone: _____

PAST TREATMENT (ADDICTION & MENTAL HEALTH)

Treatment Type	# of admits	Facility Name (of most recent treatment)	Dates
Detoxification			
Inpatient Psychiatric			
Residential			
Halfway house			
Sober House			
Intensive Outpatient (IOP)			
Outpatient therapy			
Couple/family therapy			
Suboxone, Methadone maintenance			

PATIENT NAME: _____

DRUG USE HISTORY

Primary Drug(s): _____ **Secondary:** _____

✓ if used in the past year	Drug	Age First Use	Last Use	Frequency	Amount
	Alcohol				
	Amphetamines				
	Benzodiazepines (Klonopin, Xanax, Valium Ativan)				
	Cocaine				
	Fentanyl				
	GHB				
	Hallucinogens (mushrooms, LSD, PCP, DXM)				
	Heroin				
	Inhalants				
	Ketamine				
	Marijuana				
	MDMA (Ecstasy)				
	Methadone				
	Methamphetamine				
	Morphine				
	Over the counter (cough syrup, Asthma Inhalers, Laxatives, Diet Pills, Cold Medicines, Ephedrine, Sleeping Pills, Benadryl				
	Oxycontin, Oxycodone, Percocet				
	Rohypnol				
	Steroids (Anabolic)				
	Suboxone				
	Tobacco				
	Other:_____				

MEDICATIONS: List all current medications

MEDICAL

Date of Last Physical:_____

Primary Care Physician:_____ Phone_____

List Any current medical conditions:

Name of Medication	Dosage	Reason Taking

PATIENT NAME: _____

RISK FACTORS

History of Suicide attempts	☐ No ☐ Yes: _____
Present Suicidal ideation	☐ No ☐ Yes: _____
Self-harm(past/present)	☐ No ☐ Yes: _____
Harm to others	☐ No ☐ Yes: _____
Fire-setting	☐ No ☐ Yes: _____
Access to firearms	☐ No ☐ Yes: _____
Trauma History	☐ No ☐ Yes: If yes do you feel that trauma may affect your recovery? ☐ No ☐ Yes

LEGAL

Any current legal charges	☐ No ☐ Yes: _____
On probation	☐ No ☐ Yes: _____
Upcoming Court Dates	☐ No ☐ Yes: _____
Restraining orders	☐ No ☐ Yes: _____

AFTERCARE PLANS- (Please note) Insurance companies decide length of stay, which is usually 10-12 days, once they deny approval you usually need to discharge the next day, so it is important to work on aftercare plans from the beginning of your admission.

HOUSING: ☐ Return Home ☐ Sober House ☐ Residential Program ☐ Friends ☐ Homeless ☐ Other _____

Emergency Placement if needed to leave program unexpectedly:_____

TREATMENT: ☐Back to current providers ☐ Partial ☐ IOP ☐ Individual Therapist/Psychiatrist ☐ Group

☐ Another Program ☐Self Help ☐Unsure

ANY ADDITIONAL COMMENTS: _____

_____

***Upon completion of this application, Fax to: 978-827-4809. Call within 48 hrs 978-827-5115 (ask for John or Noelle). Applications will be kept on file for 10 days only. If appropriate, a telephone interview will be schedule with you. Applications are assessed for need, ability to participate successfully, motivation for sobriety and with meeting insurance criterion**

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Pre-Admit Form

Patient Name:_____ **Date:** _____ **Program:** ☐ **ART or** ☐ **PHP**

Patient DOB:_____ Age:_____ Telephone #:_____

Address:_____ City/State:_____ Zip: _____

Primary Insurance:_____ Telephone#:_____

Insurance ID#:_____ Group# (if applicable): _____

*Subscriber Name: _____ *Subscriber DOB: _____

Secondary Insurance:_____ Telephone#:_____

Insurance ID#:_____ Group# (if applicable): _____

*Subscriber Name:_____ *Subscriber DOB: _____

Pharmacy Information

In order to be prescribed medication at Naukeag the following information is <u>required</u>. If you don't have a prescription card call your pharmacy and they will be able to give you the information.

Cardholder I.D.: _____ RxBIN: _____

RxGroup: _____ Person Code: _____ Pharmacy: _____

Town: _____ Phone Number: _____

Do you have any allergies? _____

You are responsible for all co-pays which you may pay in cash or by credit card. The card number can be called into the pharmacy.

<u>STOP PROGRAM USE ONLY</u> **<u>FAX TO PT ACCOUNTS 617-855-2366</u>**

Is Precertification Required? Y N Telephone #: _____

Information Received: