Edgewater Recovery Center

Referral Form

Name: _____ Date: _____

SS#: _____ DOB: _____ Age: _____

Address:_____

_____

Phone#__ __ __ - __ __ __ - __ __ __ __ Alternate Phone # __ __ __ - __ __ __- __ __ __ __

County of Residence_____

PAY SOURCE: _____

NAME OF INSURANCE: _____

If Court Order, How Long is order for: _____

County or Court Contact: _____ PH# _____

Referral Source_____

Referral Phone# __ __ __ - __ __ __ - __ __ __ __

Person Giving information if other than client and relationship: _____

If incarcerated what is the date of incarceration:_____

Attorneys Name_____

Attorney Phone #__ __ __ - __ __ __ - __ __ __ __

Attorney Fax # __ __ __ - __ __ __ - __ __ __ __

Current legal issues/ Court dates with in the next 6 months:

_____

Current DUI YES / NO Offense Date _____

Probation / Parole YES / NO Officers Name _____

Do you have to register with Megan's Law (Sex Offender)? Yes / No

Previous treatment (when, where, was it beneficial) (inpatient, outpatient, IOP, or MAT)

_____

_____

Drug History: (Name of drug, frequency and amount used): _____

_____

LAST USE OF CHEMICALS:

- Date of last use: _____
- Specific Drug / Drugs Used: _____
- Amount: _____
- How Used: _____ Oral _____ IV,

  _____ Intranasal _____ Inhalation (huff)

CAGE_AID QUESTIONS:

1. Have you ever felt that you ought to cut down on your drinking or drug use? Yes/No
2. Have people annoyed you by criticizing your drinking or drug use? Yes/No
3. Have you ever felt bad or guilty about your drinking or drug use? Yes/No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid

   SCORING: Regard one or more positive responses to CAGE_AID as positive screen. SCORE_____

IV DRUG USE YES / NO

HEART PROBLEMS YES / NO

DIABETES YES / NO

BLEEDING YES / NO

DT'S / BLACKOUTS YES / NO

Suicide Risk YES / NO Explain: _____

Dual Diagnosis YES / NO Other DX _____ (such as schizophrenia)

Seizures YES / NO Date of last seizure_____

Medications for Seizures: _____

Allergies: _____Bring EPIPEN if needed.

Any Pertinent Medical Conditions? YES / NO List:_____

_____

Do you need accommodation for the use of medical devises? (breathing apparatus, wheel chair etc..) _____

MEDICATIONS Prescribed by a physician and dosage: _____

_____

Have you ever been diagnosed with HEP A, B or C? ____ if so, when_____

Has you ever received the vaccinations for HEP A,B,or C? If so, when_____

Dependent Children YES / NO

Ages: _____

Who currently has custody? _____

Marital Status: ___Single ___Married ___Widowed ___Divorced ___Never Married

Are you currently Employed? YES / NO

Do you receive income from a physical or mental disability? YES / NO

What age did you begin using?_____

What started you on this path? Give a brief description of any traumas from your past.

_____
_____
_____
_____
_____
_____

What is your current living situation? Are there any sober supports?

_____
_____
_____

What is the family history of addiction?

_____
_____

_____

_____

Are you currently, or have you ever, been prescribed medications for a mental or behavioral disorder? If so, what were you diagnosed with, and what were you prescribed.

_____

_____

_____

_____

What was the last grade completed in school? _____

Does client have transportation arranged? YES/NO

What are those arrangements? _____

INFORM CLIENTS OF THE FOLLOWING:

90-day supply of medications or enough refills

Bring clothes

Bring personal toiletries MUST BE NEW AND UNOPENED OR THEY WILL BE DISPOSED OF!

Give numbers to other residential facilities (if Needed)

CLIENT MUST CALL IN WEEKLY TO CHECK IN ON WAITING LIST

IF THIS IS AN ASW REFERRAL, PLEASE ATTACH ASSESSMENT INTERVIEW INFORMATION!

NOTES_____

_____

_____

_____

_____

_____

STAFF MEMBER TAKING INFORMATION: _____