Referral Information

Initial Contact Date: _____ **Completed By:** _____

Updated On: _____ **Update By:** _____

Adult: ☐ Clinton ☐ Warrensburg ☐ Cedar Ridge ☐ McCambridge **Date or ASAP:** _____

Adolescent: ☐ Clinton ☐ Columbia ☐ Rolla

- PERSON BEING REFERRED -

Name: _____ **Sex:** ☐ Male ☐ Female **TENTATIVE ADMIT DATE:** _____

Age: _____ **DOB:** _____ **SSN:** _____ **Race:** _____

Address: _____ **City/State/ZIP:** _____ **County:** _____

Telephone: _____ **Additional Phone:** (To contact you for additional information prior to admission _____ **Email:** _____

Have you ever been in TX with us before? ☐ Yes ☒ No, if so ☐ Pathways ☐ Cedar Ridge ☐ McCambridge

McCambridge Use Only:

Number in Household: _____ **Number of Dependents:** _____ **Age of Dependents:** _____

Pregnant: ☐ Yes ☐ No **Children to Residential:** ☐ Yes ☐ No

Children Special Need:

- INSURANCE INFORMATION -

Primary Insurance: _____ ID Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Employer: _____ Subscriber SSN (If different from person being referred) _____

Group Number: _____ Insurance Phone Number: _____

- GUARDIAN INFORMATION -

Do you have a legal guardian? ☐ Yes ☐ No If Yes, provide contact information below:

Name: _____

Address: _____ City/State/ZIP: _____

Relation: _____ Email Address: _____

Telephone: _____ Cell Phone: _____ Work Phone: _____

- REFERRING AGENCY OR PERSON -

Referring Agency: _____ Name: _____ County: _____

Address: _____ City/State/ZIP: _____

Relation: _____ Email Address: _____

Phone Number: _____ Fax Number: _____

- EMERGENCY CONTACT -

Emergency Contact: _____

Address: _____ City/State/ZIP: _____

Relation: _____ Email Address: _____

Telephone: _____ Cell Phone: _____ Work Phone: _____

- PRESENTING ISSUES -

Why are you seeking treatment?

- LEGAL STATUS -

Legal Status: ☐ Does Not Apply ☐ Awaiting Disposition ☐ Incarcerated ☐ On Probation ☐ On Parole

If arrested, was it a ☐ felony or a ☐ misdemeanor? Date of arrest: _____

Any pending charges? _____

Number of arrests during the last 30 days: _____ Is there a court day scheduled within the next 30 days? ☐ Yes ☐ No

Number of lifetime arrests: _____

Number of lifetime DUI arrests: _____ If Yes, when? _____

Probation Officer Name (if not referring person): _____ **Phone:** _____

Can we release information to the probation officer? ☐ Yes ☐ No

Is individual court ordered to treatment? ☐ Yes ☐ No (if Yes, we MUST have a copy of the order)

Is individual a sex offender? ☐ Yes ☐ No

Court Order Status: _____ **Drug Court Status:** _____

DFS Involvement ☐ Yes ☐ No Name of caseworker: _____

Can we release information to the caseworker? ☐ Yes ☐ No **Do you receive TANF?** ☐ Yes ☐ No

DOC ID #: _____ **High Risk** ☐ Yes ☐ No

- ADOLESCENT REFERRALS ONLY -

Physical exam in last 6 months? ☐ Yes ☐ No **Immunizations up to date?** ☐ Yes ☐ No

Runaway Risk? ☐ Yes ☐ No History of Runaway? _____

Last 30 Days? _____

Current Concerns? _____

Who has custody? _____ **Contact restrictions:** _____

Parent: _____

☐ Mother or ☐ Father or ☐ Other

Legal Guardian? ☐ Yes ☐ No

Address: _____

City, State, ZIP: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Parent: _____

☐ Mother or ☐ Father or ☐ Other

Legal Guardian? ☐ Yes ☐ No

Address: _____

City, State, ZIP: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

- ADULT REFERRALS ONLY -

Do you have a payee? ☐ Yes ☐ No If Yes, provide contact information below:

Name: _____

Address: _____ City/State/ZIP: _____

Relation: _____ Email Address: _____

Telephone: _____ Cell Phone: _____ Work Phone: _____

- ALCOHOL AND SUBSTANCE USE HISTORY -

Is individual an IV drug user? ☐ Yes ☐ No Last known use:

Primary Substance:	**Secondary Substance:**
Route: ☐ Inhalation ☐ Oral ☐ IV Injection ☐ Smoking ☐ Non-IV Injection	**Route:** ☐ Inhalation ☐ Oral ☐ IV Injection ☐ Smoking ☐ Non-IV Injection
Number of Days Used in Past 30 Days: **Age of First Use:**	**Number of Days Used in Past 30 Days:** **Age of First Use:**
Last Date of Use: **Frequency of Use:**	**Last Date of Use:** **Frequency of Use:**
Tertiary Substance: SEX ADDICTION	**Prior Detox:** **Prior Residential:** **Prior Outpatient:**

Route: ☐ Inhalation ☐ IV Injection ☐ Non-IV Injection	☐ Oral ☐ Smoking	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
Number of Days Used in Past 30 Days:	**Age of First Use:**			
Last Date of Use:	**Frequency of Use:**			

In the past 30 days, how many days did individual attend self-help programs? _____

- GENERAL INFORMATION FOR ALL REFERRALS -

Are there any physical limitations? _____

Any physical health problems? ☐ Yes ☐ No _____

Any mental health disorders? ☐ Yes ☐ No _____

Thoughts of Harm to Self?
☐ Plans ☐ Threats ☐ Attempts

Previous Attempts? _____
Last 30 Days? _____
Current Concerns? _____

Thoughts of Harm to Others?
☐ Plans ☐ Threats ☐ Attempts

Previous Attempts? _____
Last 30 Days? _____
Current Concerns? _____

History of Assaultive Behaviors?
☐ Yes ☐ No

History of Seclusion or Restraint? _____
Last 30 Days? _____
Current Concerns? _____

Note: If any questions above are answered "Yes," consultation with the Director or designee is required before admission is scheduled.

- INFORMATION FOR THE CLIENT -

Clients need to bring:
2 Forms of ID
All medications and refills for length of stay
Payer information
Court orders.
In addition adolescents need:
Legal guardian present for signature
Custody papers
Bring most recent physicals (may be able to get from school.)

- INFORMATION CONTINUED -

Military Status:

Dates of Service: From: _____ To: _____

Branch of Service: _____ Rank/Position: _____

Additional Information:

☐ Yes ☐ No 1. Have you or a family member ever had a drinking problem or abused drugs?

☐ Yes ☐ No 2. Have you ever felt you should cut down on your drinking problem or abused drugs?

☐ Yes ☐ No 3. Have people annoyed you by criticizing or complaining about your drinking or drug use?

☐ Yes ☐ No 4. Have you ever felt bad or guilty about your drinking or drug use?

☐ Yes ☐ No 5. Have you ever had a drink or drug in the morning (eye opener) to steady your nerves or get rid of a hangover?

☐ Yes ☐ No 6. Do you use any mood altering drugs other than those prescribed by a physician?

If yes, please list: _____

☐ Yes ☐ No 7. Do you have problems with gambling?

Primary Care Physician: _____

Address: _____ City/State/ZIP: _____

Relation: _____ Email Address: _____

Phone Number: _____ Fax Number: _____

If yes, what are the restrictions? _____

Current Living Arrangements:

☐ <18 w/ both parents	☐ 18 & > w/ alone	☐ 18 & > w/ homeless shelter
☐ <18 w/ single parents	☐ 18 & > w/ family	☐ 18 & > w/ jail/correctional facility
☐ <18 w/ other relatives	☐ 18 & > w/ unrelated person	☐ 18 & > w/ homeless
☐ <18 w/ foster home	☐ 18 & > w/ adult foster care	☐ 18 & > w/ spouse only
☐ <18 w/ private care facility	☐ 18 & > w/ nursing home	☐ All ages w/ Oxford House
☐ <18 w/ public care facility	☐ 18 & > w/ transitional	☐ All ages w/ CSTAR Supported Housing
☐ <18 w/ independent living	☐ 18 & > w/ other public/private	☐ All ages w/ CSTAR Residential
☐ <18 w/ other	☐ 18 & > w/ parent or siblings	☐ All ages w/ refused to answer
☐ <18 w/ parent/step parent	☐ 18 & > w/ other	☐ Residential Care Facility (RCF)

Is the individual intoxicated? ☐ Yes ☐ No

If yes, what drugs have they used and when?

1. _____ 2. _____ 3. _____

Sexual/Drug History:

Have you ever had sex with:

☐ Male	☐ HIV+ partner	☐ High risk partner
☐ Female	☐ IV drug user	☐ Partner high on any kind of substance

Have you received drugs/money for sex? ☐ Yes ☐ No

Have you ever been paid for sex? ☐ Yes ☐ No

Have you been a victim of sexual assault? ☐ Yes ☐ No

If yes, was it reported to the police? ☐ Yes ☐ No

Have you had sex with alcohol use? ☐ Yes ☐ No

Have you ever injected drugs? ☐ Yes ☐ No

Have you ever shared needles? ☐ Yes ☐ No

Have you used crack? ☐ Yes ☐ No

Other drug use? ☐ Yes ☐ No

Specify pain pills: _____

Have you ever had one of the following STDs?

☐ Gonorrhea	☐ Chlamydia	☐ PID
☐ Genital warts	☐ Syphilis	
☐ Herpes	☐ Yeast Infection	

Ever used one of the following prevention methods?

☐ Birth Control Pill	☐ BTL	☐ Other
☐ IUD	☐ Foam	
☐ Diaphragm	☐ Condom	

Date of last sexual/needle sharing exposure: _____

Number of sexual/needle sharing partners in the last six (6) months: _____

Have you ever been tested for HIV? ☐ Yes ☐ No If yes, when _____, and where _____

Are you HIV positive? ☐ Yes ☐ No

Have you ever been tested for TB? ☐ Yes ☐ No If yes, when _____, and where _____

Do you have TB? ☐ Yes ☐ No

Have you had close contact with someone who has infectious TB? ☐ Yes ☐ No

Have you ever had infectious TB symptoms that include: ☐ Cough ☐ Fever ☐ Chest Pain ☐ Night Sweats

Do you have ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

Is the individual a resident of Missouri? ☐ Yes ☐ No

Public Assistance Received (check all that apply)**:**

- ☐ None
- ☐ Black Lung Disease Benefits
- ☐ College Work/Study Programs
- ☐ Food Stamps
- ☐ General Relief
- ☐ Government Pensions
- ☐ Grants to Assist Victims of Domestic Violence
- ☐ Head Start
- ☐ Higher Education Grants
- ☐ Higher Education Loans
- ☐ In-Home Supportive Services
- ☐ Job Opportunities & Basic Skills Training
- ☐ Legal Services for the Poor
- ☐ Low-Income Home Energy Assistance
- ☐ Medicaid
- ☐ Medicare
- ☐ Mental Retardation & Developmental Disabilities
- ☐ Missouri Crime Victim Compensation
- ☐ Other
- ☐ Other Subsidized Housing
- ☐ Psychiatric Services
- ☐ Public Housing
- ☐ Railroad Retirement Benefits
- ☐ Refugee Assistance
- ☐ School Lunch Assistance
- ☐ Section 8 Housing Payments
- ☐ Section 8 Housing Vouchers
- ☐ Social Security Disability Benefits
- ☐ Social Security Retirement Benefits
- ☐ Social Security Survivor's Benefits
- ☐ Substance Abuse Treatment Assistance
- ☐ Supplemental Security Income
- ☐ Temporary Assistance to Needy Families
- ☐ Trade Adjustment Assistance
- ☐ Unemployment Compensation
- ☐ Veterans' Compensation
- ☐ Veterans' Pensions
- ☐ Worker's Compensation

Employment Status:

- ☐ Employed – Full-Time (35+ hrs/wk)
- ☐ Employed – Part-Time (<35 hrs/wk)
- ☐ Sheltered Workshop
- ☐ Supported Employment
- ☐ Unemployment – Sought last 30 days or on layoff
- ☐ Not in Workforce – Homemaker
- ☐ Not in Workforce – Student (acad or vocational)
- ☐ Not in Workforce – Inmate of Institution (invol)
- ☐ Not in Workforce – Other

Name of Employer: _____

Income: _____ ☐ weekly ☐ monthly

Marital status: ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married ☐ Other

Education:

- ☐ Kindergarten
- ☐ 1st Grade
- ☐ 2nd Grade
- ☐ 3rd Grade
- ☐ 4th Grade
- ☐ 5th Grade
- ☐ 6th Grade
- ☐ 7th Grade
- ☐ 8th Grade
- ☐ 9th Grade
- ☐ 10th Grade
- ☐ 11th Grade
- ☐ 12th Grade
- ☐ G.E.D.
- ☐ 1st Year College
- ☐ 2nd Year College
- ☐ 3rd Year College
- ☐ 4th Year College
- ☐ Graduate College
- ☐ 1 Yr Graduate
- ☐ 3 Yr Graduate
- ☐ Doctorate Degree
- ☐ Master Degree
- ☐ No Academic
- ☐ Tech Ed in addition to High School
- ☐ Tech Ed in lieu of High School

Special Education:

- ☐ Behavior Disordered Classroom
- ☐ Educable Mental Retardation
- ☐ Elementary/Secondary Special Education
- ☐ Learning Disabled Classroom
- ☐ No Special Education
- ☐ Not Collected
- ☐ Remedial Reading
- ☐ Resource Room
- ☐ Special Education (unspecified)
- ☐ Special Education Testing Suggested
- ☐ Special School
- ☐ Speech Therapy
- ☐ Trainable Mental Retardation

GPA:

- ☐ A/A+
- ☐ A-
- ☐ B+
- ☐ B
- ☐ B-
- ☐ C+
- ☐ C
- ☐ C-
- ☐ D+
- ☐ D
- ☐ D-
- ☐ F
- ☐ Not Applicable

School Name: _____ Status: _____

Developmental Issues (*such as having been on an IEP, or tested for special needs, attended special needs classes, difficulty ready or writing, etc.***):**

Comments or description of this individual, such as personality, attitude, behavior, etc:

- CHILD CUSTODY AND DRUG-FREE BIRTHS INFORMATION -

Number of children returned to individual's custody from DFS: _____

Number of live births during treatment (females only): _____

Of the live births during treatment, how many were drug free births? (females only): _____

If "Drug Free Births" response is less than number of live births, what is the primary reason for infant's drug/alcohol exposure? (females only):

- ☐ Entered treatment and delivered shortly thereafter
- ☐ Relapse
- ☐ Tested positive for drug with a short half-life
- ☐ Unknown

HIV Test Results:

- ☐ AIDs/ARC Diagnosis
- ☐ HIV Negative
- ☐ HIV Positive
- ☐ HIV Status Unknown

- ADDITIONAL INFORMATION -

Psychiatric History:

- CURRENT MEDICATION -

Name (prescription and over the counter)	**Dosage/How Prescribed?**	**Reason?**	**Results?**

- PHYSICAL OR PSYCHOLOGICAL CONCERNS -

If yes, name the condition(s) and note if they have been under a doctor's care for this condition within the past 90 days:

Also, list any current medications they are now taking for this condition:

Have they ever been diagnosed with a mental health disorder? ☐ Yes ☐ No

If yes, list diagnosis: _____

Month/Year diagnosis given: _____ Last date they saw a doctor: _____

List medications prescribed for this disorder: _____

Are they currently taking these medications? ☐ Yes ☐ No If no, why not? _____

- STAFF ONLY BELOW THIS LINE -

- INTERNAL REFERRALS -

Local Chart Number: _____ DMH Number: _____ Anasazi Number: _____

Please indicate which tasks have been completed prior to transfer:

- ☐ CHAT/ASI
  Date of Assessment: _____
- ☐ ADA/TEDS Update
- ☐ Completed Admission
- ☐ Diagnosis
- ☐ Change Notice
- ☐ Clinical Review (if indicated)

Current Authorized Releases of Information:

1. _____ 2. _____ 3. _____

- ACTION TAKEN -

Screening Scheduled On: _____ With: _____

Residential Admission Scheduled: _____ Outpatient Admission Scheduled: _____

Comments:

- FINANCIAL -

Proof of Income: _____ Income Source: _____

Type: ☐ Employment ☐ SSI ☐ Disability

Monthly Income: _____ ☐ Other: _____