Compass Health Network

Referral Information

Initial Contact Date: ______ **Completed By:** ______
Updated On: ______ **Update By:** ______

- PERSON BEING REFERRED -

Name: ______ **Sex:** ☐ Male ☐ Female **TENTATIVE ADMIT DATE:**
Age: ______ **DOB:** ______ **SSN:** ______ **Race:** ______
Address: ______ **City/State/ZIP:** ______ **County:** ______
Telephone: ______ **Cell Phone:** ______ **Work Phone:** ______
Number in Household: ______ **Number of Dependents:** ______ **Email:** ______

- REFERRING AGENCY OR PERSON -

Referring Agency: ______ Name: ______ County: ______
Address: ______ City/State/ZIP: ______
Relation: ______ Email Address: ______
Phone Number: Fax Number:

Emergency Contact: ______
Address: ______ City/State/ZIP: ______
Relation: ______ Email Address: ______
Telephone: Cell Phone: Work Phone:

- PRESENTING ISSUES -

Why are you seeking treatment?

- ADULT REFERRALS ONLY -

Do you have a guardian? ☐ Yes ☐ No If Yes, provide contact information below:
Name: ______
Address: ______ City/State/ZIP: ______
Relation: ______ Email Address: ______
Telephone: ______ Cell Phone: ______ Work Phone: ______

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: ______

Medical Clearance Needed? ☐ Yes ☐ No
Court Order Status: ______ **Drug Court Status:** ______
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?

- ADOLESCENT REFERRALS ONLY -

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

Primary Care Physician: ______________________________

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

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

Parent: ______________________________
☐ Mother or ☐ Father or ☐ Other
Legal Guardian? ☐ Yes ☐ No
Address: ______________________________
City, State, ZIP: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Work Phone: ______________________________
*** Court Order Status:**

Parent: ______________________________
☐ Mother or ☐ Father or ☐ Other
Legal Guardian? ☐ Yes ☐ No
Address: ______________________________
City, State, ZIP: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Work Phone: ______________________________
*** Court Order Status:**

Legal Guardian: ______________________________
Relationship: ______________________________
Address: ______________________________ City/State/ZIP: ______________________________
Telephone: ______________ Cell Phone: ______________ Work Phone: ______________

*** Court Order Status:** ______________________________

* *(bring any custody papers)*

- GENERAL INFORMATION FOR ALL REFERRALS -

Is individual a registered sex offender? ☐ Yes ☐ No
If yes, what are the restrictions? ______________________________

Are there any physical limitations? ______________________________

Current Living Arrangements:

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

Is the individual pregnant? ☐ Yes ☐ No

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

Have you received drugs/money for sex? ☐ Yes ☐ No
Have you been a victim of sexual assault? ☐ Yes ☐ No
Have you had sex with alcohol use? ☐ Yes ☐ No
Have you ever shared needles? ☐ Yes ☐ No
Other drug use? ☐ Yes ☐ No
Have you ever had one of the following STDs?

Have you ever been paid for sex? ☐ Yes ☐ No
If yes, was it reported to the police? ☐ Yes ☐ No
Have you ever injected drugs? ☐ Yes ☐ No
Have you used crack? ☐ Yes ☐ No
Specify pain pills: ______________________________
Ever used one of the following prevention methods?

☐ Gonorrhea ☐ Chlamydia ☐ PID ☐ Birth Control Pill ☐ BTL ☐ Other
☐ Genital warts ☐ Syphilis ☐ IUD ☐ Foam
☐ Herpes ☐ Yeast Infection ☐ 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 Lunch 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: ______________________________

Legal Status:

☐ Does Not Apply
☐ Awaiting Disposition
☐ Incarcerated
☐ On Probation
☐ On Parole

Marital status:

☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Married
☐ Other

Probation Officer Name: ______________________________ **Phone**: ____________________

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:

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

- ALCOHOL AND SUBSTANCE USE HISTORY -

Primary Substance:		**Secondary Substance:**	
Route: ☐ Inhalation ☐ IV Injection ☐ Non-IV Injection	☐ Oral ☐ Smoking	**Route:** ☐ Inhalation ☐ IV Injection ☐ Non-IV Injection	☐ Oral ☐ Smoking
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:		**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? ____________________

Number of arrests during the last 30 days: ____________________

Number of lifetime arrests: ____________________

Number of lifetime DUI arrests: ____________________

Is there a court day scheduled within the next 30 days? ☐ Yes ☐ No

If Yes, when? ____________________

- ADDITIONAL INFORMATION -

Thoughts of Harm to Self? ☐ Plans ☐ Threats ☐ Attempts	Previous Attempts? ____________________ Last 30 Days? ____________________ Current Concerns?
Thoughts of Harm to Others?	Previous Attempts? ____________________

☐ Plans ☐ Threats ☐ Attempts	Last 30 Days? ______ Current Concerns?
History of Assaultive Behaviors? ☐ Yes ☐ No	History of Seclusion or Restraint? Last 30 Days? ______ Current Concerns?
Runaway Risk? ☐ Yes ☐ No	History of Runaway? ______ 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.

Psychiatric History:

- CURRENT MEDICATION -

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

- PHYSICAL, DEVELOPMENTAL, PSYCHOLOGICAL CONCERNS -

Does individual have any chronic physical health problems (back, heart, headaches, etc.)? ☐ Yes ☐ No

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 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? ______

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

Last known drug/alcohol use: ______

- INSURANCE INFORMATION -

Primary Insurance: ______ ID Number: ______

Subscriber Name: ______ Subscriber DOB: ______

Employer: ______

Group Number: ______ Insurance Phone Number: ______

- STAFF ONLY BELOW THIS LINE -

- INTERNAL REFERRALS -

Local Chart Number: ____________ DMH Number: ____________ AVATAR Number: ____________

Please indicate which tasks have been completed prior to transfer:

☐ GAIN/ASI ☐ ADA Update ☐ Completed Admission

Date of Assessment: ____

☐ 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: ____________________