Addiction Treatment Services
at Villa of Hope
LIFE Program
3300 Dewey Avenue
Rochester, NY 14616
Phone:(585) 865-1555x269 Fax:(585) 663-1709

REFERRAL FOR RESIDENTIAL TREATMENT

Referral Agency Name: _____

Staff Contact: _____ Phone #: _____

Address: _____

_____

Client Name: _____ Date of Birth: _____

Primary Language: English ☐ Other ☐ _____

Address: _____ SS#: _____

_____
City State Zip Code County

Phone #: (1) _____ (2) _____
Area Code Area Code

Emergency Contact Name: _____

Phone #: _____ Relationship: _____

Custodial Parent/Guardian: _____

Address: _____

Phone #: _____ Relationship: _____

Circumstances leading to referral: _____

_____

_____

_____

_____

Substances

Drugs	Choice	Frequency	Suboxone Referral
Alcohol			Yes No
Cannabis			
Cocaine			
Heroin			
Prescription Drugs			
Other			

Previous Treatment for Chemical Abuse/Dependency

Type of Treatment				Name of Facility	Dates of Treatment		Completed	
I/P	OP	Detox	Res		From	To	Yes	No

Current or Previous Medical Problems

Medical Problem	Physician	Date last seen	Medication

Current Medical Provider: _____

Address: _____

Phone: _____ Fax: _____

Previous Psychiatric Treatment

Type of Treatment		Facility/Practitioner's Name	Dates of Treatment		When	
I/P	OP		From	To	Past	Current

Current or Past Psychotropic Medication

Medication	Physician	Date last seen	Past	Current

Current Psychiatric Concerns: No ☐ Yes ☐ Explain: _____

_____

_____

Legal Involvement

Is client on probation?	Yes / No
County?	
Probation officer contact information	Name: Phone number:
Does client have past or pending criminal charges?	Explain:
Is this an alternative to incarceration or detention?	Explain:

Please answer the following specific question: (must be completed)

Has this client ever attempted suicide?	No	Yes	Explain:
Has this client ever experienced homicidal behavior?	No	Yes	Explain:
Has this client ever experienced any psychotic symptoms? (hallucinations, paranoia, thought disturbances)	No	Yes	Explain:
Has this client had a Mental Hygiene Arrest? (If yes, include records)	No	Yes	Explain:
Has this client ever been refused placement at another agency?	No	Yes	Explain:
Does the client have a history of fire setting/bomb building/violence towards others?	No	Yes	Explain:
Is there a history of this client being a perpetrator of sexual or physical abuse?	No	Yes	Explain:

Education

Name of current school district and school**:**

_____

Current Grade: _____

Current or past 504/IEP support services? _____

Any school concerns? _____

School Counselor contact information: _____

All Insurance Information Must Be Completed

Medicaid: Yes ☐ No ☐ Pending ☐

Manage Care: Yes ☐ No ☐

Medicaid Number: _____

County Worker's Name _____ Phone #: _____

Clients with Medicaid may have additional insurance, complete below.
All Insurance Information Must Be Completed

Insurance Company: BC/BS ☐ MVP ☐ Other ☐ _____

Number: _____ Group Code: _____

Subscriber: _____

Employer: _____

Does client have any physical health issues? No ☐ Yes ☐ Explain: _____

Please enclose, with this referral, copies of these most recent documents and assessment:

Chemical dependency evaluation ☐

Copy of medical insurance cards, physical, immunization records ☐

School records, including IEP if applicable ☐

Psychiatric evaluation (required) ☐

Probation, parole, other legal documents ☐

Any missing information or records may result in prolonged admission process.

revised 7/25 AJ.