INPATIENT REHAB REFFERAL

Client Information Sheet

Client Name:_____ **Social Security Number:**_____ **Preferred Name:** _____

Gender: _____ **Pronouns:** He/Him She/Her They/Them Other: _____ **Sexual Orientation:** _____

DOB:_____ **Race/Ethnicity:**_____ **Primary Language:**_____ **Phone Number:** _____

Are you currently homeless? (Please Circle): YES NO **If YES, do you live in a shelter? (Please Circle):** YES NO

If YES, please record your current zip code: _____

Address: _____

_____ **County:** _____

Are you a registered sex offender? (Please Circle): YES NO

Due to the location of Living Hope Treatment Center, persons on the sex offender registry are unable to be admitted

Insurance Carrier: _____ **Policy Number:** _____ **CIN#:** _____

Marital Status (Please Circle): SINGLE MARRIED LIVING AS MARRIED SEPARATED WIDOWED DIVORCED

Employment Status (Please Circle): UNEMPLOYED FULL-TIME PART-TIME RETIRED DISABLED

Do you participate in any DSS programs such as SNAP? (Please List): _____

Are you a member of the armed forces? (Please Circle): YES NO **Are you a veteran? (Please Circle):** YES NO

Highest Grade Level Completed: _____ **HS Diploma (Please Circle):** YES NO **GED (Please Circle):** YES NO

College (Please Circle): NONE SOME COLLEGE ASSOCIATES DEGREE BACHELOR'S DEGREE MASTER'S DEGREE

Active CPS case (Please Circle): YES NO **Drug Treatment Court System (Please Circle):** YES NO

Probation (Please Circle): YES NO **Parole:** YES NO **Reason:** _____

PO's Information (if applicable):_____

Primary Substance	**Substance #2**	**Substance #3**	**Substance #4**
IV SNIFF SMOKE ORAL	IV SNIFF SMOKE ORAL	IV SNIFF SMOKE ORAL	IV SNIFF SMOKE ORAL
How often? _____ How much? _____	How often? _____ How much? _____	How often? _____ How much? _____	How often? _____ How much? _____
Age of first use:	Age of first use:	Age of first use:	Age of first use:
Date of last use:	Date of last use:	Date of last use:	Date of last use:
Length of Use at This Rate:	Length of Use at This Rate:	Length of Use at This Rate:	Length of Use at This Rate:

Do you smoke cigarettes? (Please Circle): YES NO FORMER **Do you vape? (Please Circle):** YES NO FORMER

How much in a day?_____ **Age you first tried it?** _____

Please list any allergies you may have.

Food Allergies	Medication/Latex/Adhesive Allergies

Medical History (Please Circle)

History of Seizures	YES NO	Date of last seizure:
Diabetes	YES NO	TYPE 1 TYPE 2 **INSULIN DEPENDENT:** YES NO
Heart Disease	YES NO	Notes:
High Blood Pressure	YES NO	Notes:
Blood Clots	YES NO	Notes:
Cirrhosis/Liver Failure	YES NO	Notes:
Hepatitis	A B C	**Have you been vaccinated for Hepatitis?** YES NO UNSURE
Surgeries	YES NO	Explain:
Mental Health Concerns	YES NO	Explain:
Other	YES NO	Explain:

Are you currently engaged in other chemical dependency treatment? (Please Circle): YES NO

If YES, where/with whom? _____

Do you attend meetings (AA, NA, etc.)? (Please Circle): YES NO

If yes, which groups? _____

Are you currently engaged in mental health treatment? (Please Circle): YES NO

If YES, where/with whom? _____

Currently (Please Circle): SUICIDAL IDEATION HOMICIDAL HALLUCINATIONS OTHER: _____

Suicidal ideations within the past 6 months? (Please Circle): YES NO

Do you have a primary care provider/practice: _____

Current Medications

Are you on Suboxone? (Please Circle): YES NO **Are you on Methadone? (Please Circle):** YES NO

Name of Medication/Dosage Information	Did you bring it with you? (Please Circle)
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO

Date of last Vivitrol or Sublocade dose (if applicable): _____

Who is referring you into treatment? _____

Gregory E. Polisseni Living Hope Treatment Center

Living Hope Treatment Center — a first-of-its-kind, integrated recovery and mental health facility. We are providing the community life-changing support, programs, and resources to help individuals move forward.

The opening of the Living Hope Treatment Center in 2022, marks a new beginning for Villa of Hope and individuals who are battling substance use disorders and working to better their mental health and wellness. Our center will provide life-changing opportunities for families and individuals to find hope and to recover and rebuild their lives

Include with Referral:

- Release of information
- LOCADTR
- Recent biopsychosocial
- PPD
- Recent lab work
- History and physical
- Urine screen results
- Complete medication list

What to Bring:

- 5-7 days of clothing, including season appropriate clothing items such as jackets, gloves, hats.
- Appropriate pajamas
- Prescribed medications
- Journals, books, puzzle books
- Appropriate footwear, including shower shoes if wanted
- Personal hygiene supplies (contains no alcohol, non aerosols)

What NOT to Bring:

- Electronics
- Hair clippers including razors, or styling devices
- Weapons
- Alcohol, drugs, paraphernalia, lighters, matches, or vapes
- Clothing that includes expletives, drug or alcohol references, political wear.
- Hats or bandanas (unless for religious purposes)
- Cash
- Hoodies

Please send all referrals with the required paperwork to: Ashley.Smith@Villaofhope.org.
For any questions please call 585-865-1500 EXT: 453