665 W. Fourth Street
Winston-Salem, NC 27101
336.725.8389 phone
336.800.8739 E-fax
InsightNC.org

REFERRAL REQUEST FORM
BEGIN AGAIN TREATMENT SERVICES (BATS)

Referred By: _____ Contact Person:_____

Date Referred: _____ Time: _____ Discharge Date: _____

Name:_____ Date of Birth: _____

Social Security #: _____ Medicaid #:_____ LME#:_____

Insight CMHC #: _____ Gender: ☐Female ☐Male Veteran Status ☐Yes ☐No

Address:_____

City: _____ State: _____ ZIP:_____

Mailing Address (If different) City State Zip County:

Phone: Home: _____ Cell:_____ Work: _____

Emergency Contact: _____ Phone: Relation to Client:

Prior BATS Housing Program Resident ☐Yes ☐No If yes, approximately date: _____
If yes, reason for discharge: _____

Relationship Status:

☐Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partner/Significant Other

Name of Spouse/Significant Other N/A May We Contact? ☐Yes ☐No

Telephone # (home) _____ (work) _____

Resident of North Carolina ☐ Yes ☐ No U.S. Citizen ☐ Yes ☐ No

NC Residence Documented Through (copy in client file): ☐ NCDL ☐ NC Photo ID ☐ Other

Criminal/Legal:

Have you been convicted of a crime ***during the past year***? ☐Yes ☐No
If yes, when was the most recent conviction and what charge(s)?
Year: _____ Charge(s)_____
Year: _____ Charge(s) _____
Year: _____ Charge(s) _____

Is the client currently on probation? ☐Yes ☐No
Does the client have any charges pending? ☐Yes ☐No What?

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Race Codes and Definitions:	
A	Asian
AI/AN	American Indian/Alaskan Native
A/W	Asian/White
AI/AN/W	American Indian/Alaska Native/White
AI/AN/B/AA	American Indian/Alaska Native/Black/African American
B/AA	Black/African American
B/AA/W	Black/African American/White
O/MR	Other/Multi-racial
W/C	White/Caucasian
NH/PI	Native Hawaiian/Pacific Islander

Ethnicity Codes and Definitions:	

Are you currently receiving services from another treatment provider? ☐ Yes ☐ No

Provider:_____ Phone #:_____

Do you have a Person-Centered Plan? ☐ Yes ☐ No ☐ Do not know

Do you want your family to be involved while you are in our program? ☐ Yes ☐ No

DSM-5 Diagnosis:_____

_____

Are you seeking Outpatient Opioid Treatment (Methadone/Suboxone/Buprenorphine/Vivitrol)?: ☐ Yes ☐ No

Have you previously in past history received treatment with (Methadone)? ☐ Yes ☐ No

If yes, who was the treatment provider and when? _____

Substance Abuse History (circle your choice of use): Alcohol, Cocaine, Hallucinogen, Opioid, Sedative, Hypnotic, Anxiolytic, Amphetamine, Cannabis, Inhalant, Synthetic, Gabapentin/Neurontin (Include Frequency/Pattern): _____

_____

Last use:_____/_____/_____ Number of Detoxes:_____

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Mental Health/Substance Abuse Assessment

During the past year have you had any mental health and or substance abuse treatment?

☐Yes ☐No ☐N/A

If yes, please list all mental health or substance abuse treatment experiences. Include type of treatment; inpatient/outpatient/day-treatment, residential (group home), and recovery support (i.e12 step) experiences

Facility/Provider	Date	Type of treatment

Are you currently in treatment? ☐Yes ☐ No

If yes, with whom:_____ Phone number: _____

Do you take any mental health medications? ☐Yes ☐No _____

Have you ever had thoughts of harming yourself or others? ☐Yes ☐No

Are you currently dealing with any depression? ☐Yes ☐No

Does the client want a referral for assistance with mental health issues? ☐Yes ☐No

If yes, where was the referral made to:

Number of Hospitalizations & Where: : _____

_____

Natural Supports: _____

Client's goals for treatment while in BATS: _____

_____

Aftercare plans (after leaving BATS Housing): _____

_____

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Please indicate if there is a current or previous diagnosis of:

☐ Arthritis	☐ Hallucinations/Delusions	☐ Hepatitis (A__ B__ C__)	☐ Sleep Apnea
☐ Cancer	☐ High/Low Blood Pressure	☐ Lung Disease (Asthma/COPD)	☐ Stroke
☐ Diabetes	☐ Head Injury	☐ Kidney Disease	
☐ Epilepsy/Seizure Disorder	☐ Heart Disease	☐ Open Wounds	

Other medical conditions not listed: _____

_____

Allergies: _____

Current Meds (Rx & OTC): _____

_____

Do you have a primary care physician? ☐ Yes ☐ No Name & Contact Info: _____

_____

Insurance: ☐Yes ☐No Type (If Medicaid, specify county): _____

Currently Homeless: ☐Yes ☐No Homelessness History: _____

_____

_____ _____ _____

Referral Signature, Title Referral Place of Employment Date

Please send assessment, medication administration record, and any other pertinent clinical documentation (ie, progress notes) with this application.

I, _____, ☐ consent ☐ decline to participate in services offered by Insight Human Services as indicated on this Referral Request Form.

Program requested: ☐ BATS (Treatment & Housing) ☐ BATS (Treatment) ☐ DECLINED

_____ _____

Applicant's Signature Date

_____ _____

BATS Housing Program Manager Date