**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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

myEvolv #: Gender: Female Male Veteran Status: Yes No

Race: American Indian or Alaska Native Asian Black or African American

 Native Hawaiian or Other Pacific Islander White Multiracial/Other

Hispanic or Latino: 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

NC Residence Documented Through (copy and attach to application): 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 If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving services from another provider/are you currently in treatment?  Yes No

If yes: Provider: Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DSM-5 Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you previously received treatment with Methadone? Yes No

If yes, who was the treatment provider and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Frequency/Pattern): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Last use: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ Number of Detoxes: \_\_\_\_\_

**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/substance abuse treatment experiences. Include type of treatment: Inpatient (hospital)/Outpatient/Day Treatment, Residential (group home), and recovery support (i.e, 12-Step) experiences:

|  |  |  |
| --- | --- | --- |
| Facility/Provider  | Date  | Type of treatment  |
|  |   |   |
|   |   |   |
|   |   |   |

Do you take any mental health medications? 🞎 Yes 🞎 No If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Meds (Prescribed & OTC): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Homeless: 🞎 Yes 🞎 No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature Date

***Please send assessment, medication administration record, and any other pertinent clinical***

***documentation (i.e., progress notes) with this application.***