Southern Highlands
Community Mental Health Center

First

Last

Client ID RU Staff ID

Date of Service M M - D D - Y Y

SH-713 Legends Client Referral Form

Assessment Taken By: _____

1.) Name of person making referral:_____ Agency:_____

Address of person making referral: _____

Relationship to applicant: _____ Phone:_____

Applicant's Name: _____ Age: _____ Date of Birth: _____

Applicant's Home Address: _____

Current address if different from home address: _____

Applicant's phone number (H)_____ (W)_____

Marital Status: M S W D Sep. Social Security Number: _____

Employer's Name: _____

Employer's Address: _____

Type of Admission: ❑ 1. Voluntary ❑ 2. Court Order *Please be aware that this is not a locked facility.

Applicant's Emergency Contact:_____ Relationship:_____

Emergency Contact's Phone Number: _____

Does the applicant have health coverage? Yes No

If yes, what type of health coverage? _____

It is preferred that the applicant complete the following pages. If for any reason the applicant cannot complete this application, a representative may complete the application preferably with the applicant present in order to provide accurate information.

Why are you wanting treatment now?_____

_____

_____

Please describe your substance use background for the past six months. Check drugs used indicating drugs of choice with an additional star, circle how often you used, list the amount and date of last use.

Drugs	Frequency				Amount	Date of Last Use
___ Alcohol	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Marijuana	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Cocaine	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Heroin	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Opioids	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____

___ PCP	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ LSD	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Amphetamines	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Benzodiazepines	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Barbiturates	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Inhalants	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____
___ Other (Specify)	Daily	3-5 times week	1-8 times month	Less than once month	_____	_____

Have you ever been treated at LEGENDS before? YES NO

Do you have family members currently being treated at LEGENDS? YES NO

Do you have any family members willing to be involved in your treatment if you agree? YES NO

(This would include possible family sessions, visits and passes.)

If yes, give name, relationship and phone numbers.

_____

_____

Residents of LEGENDS are required to complete daily written and reading assignments in group and homework individually. Thus, our residents are required to be able to read on at least an 8th grade level.

Are you capable of performing these tasks? YES NO

What was the last grade of school you completed? _____

Have you ever been diagnosed with any of the following conditions?

____ High Blood Pressure
____ Difficulty Walking
____ Cirrhosis
____ GI Bleeding
____ Hepatitis
____ Coronary Artery Disease
____ Renal Failure
____ Liver Disease
____ Seizure Disorder
____ Blood Clots
____ Pancreatitis
____ Diabetes: Are you insulin dependent? YES NO
____ Heart Problems: Please Specify _____
____ Inability to take oral medication
____ Tuberculosis*
____ Breathing Problems: Please Specify _____
____ Headaches
____ Other medical conditions or allergies _____
____ Disabilities, limitations, special needs _____

*You are required to submit the results of a PPD test no older than 30 days prior to your admission to LEGENDS. If you cannot provide this, you cannot be admitted. If you have a positive reading on your PPD, you will need to provide documentation stating that you have received a lung x-ray and have been cleared for Tuberculosis.

Have you ever been hospitalized for any of the above medical conditions? YES NO

If yes, which ones and when? _____

_____

Last blood pressure reading: Results _____ Date of reading _____

Do you have a medical provided? YES NO

If yes, who? _____ Phones; _____ Last seen: _____

If you've indicated having any of the above medical conditions, are your symptoms controlled by medication? YES NO

If yes, what prescribed medications are you currently taking?

Name	Dosage	Frequency	Last Taken	Condition Being Treated

If admitted to LEGENDS, you must bring a 90 day supply of medications or refills for medications. You will not be transported to doctor appointments for maintenance medications.

Are you facing legal charges? YES NO If yes, explain what they are and give any upcoming court dates.

_____

_____

_____

_____

Will you have to return to custody of the legal system? YES NO If yes, give name and telephone numbers of all persons who must be contacted prior to discharge. Please list weekend and holiday contact information as well.

_____

_____

_____

_____

Are you currently on probation or parole? YES NO If yes, list where, reason, name and contact information for P.O.

_____

_____

_____

_____

The waiting list for LEGENDS is typically 3 to 5 months. It is in your best interest to apply to all treatment facilities available to you. List other placements/treatment facilities for which you have applied. _____

_____

_____

_____

If you have applied for other facilities and have been denied, please list the facilities and why you were denied.

_____

_____

_____

_____

Have you ever been treated for a mental health problem (depression, anxiety, bipolar, etc) other than addiction? YES NO
What type of mental health problem?

_____

_____

Have you ever been hospitalized for any mental health problem other than addiction? YES NO If yes, where, when and why was it a mental hygiene?

_____

_____

_____

Do you have a history of suicide attempts of self-harm? YES NO If yes, list date and method.

_____

_____

_____

Do you have a history of violence towards others? YES NO If yes, explain.

_____

_____

_____

Have you experienced auditory or visual hallucinations? YES NO If yes, how frequent and are they related to your mental health problem?

_____

_____

_____

When you have stopped using or drinking in the past, have you experienced any of the following withdrawal symptoms?

_____ Tremors _____ Delirium Tremors _____ Hallucinations _____ Insomnia _____ Seizures _____ Sweats

_____ Agitation _____ Irritability _____ Nausea/Vomiting _____ Mood Swings _____ Blackouts _____ Muscle Aches

In the last 6 months, what has been your longest period of abstinence? _____

Have you used IV in the passed 6 months? YES NO Have your ever used IV? YES NO

Have you ever been in treatment for detox? YES NO If yes, where and when?

_____

_____

_____

Have you ever received outpatient substance abuse treatment, this includes methadone and suboxone treatment. YES NO If yes, where, when and how long were you clean after completing treatment?

_____

_____

_____

Have you ever been to an inpatient rehabilitation facility? YES NO If yes, when and how long were you clean after completing treatment?

_____

_____

_____

Have you ever attended AA/NA or other recovery support groups? YES NO If yes, where and when?

_____

_____

_____

You have now completed the application portion of our referral process. Please verify that all areas have been answered to the best of your knowledge. If areas have been left blank, this could delay approval and placement on our waiting list.

Applicant's Signature: _____ Date: _____

If you aided applicant in completing this application please sign below

_____ Date: _____

Relation: _____