L. E. G. E. N. D. S
All Male 28 Day Program

"Learning, Enjoying, Growing, Evolving, Nurturing, Doing, and Succeeding".

Southern Highlands
community mental health center

W.A.V.E.S
All Female 28 Day Program

"Women Achieving Values, Esteem, and Sobriety"

Substance Abuse Residential Consumer Referral Form

Date Referral is being made: _____

Name of person making referral: _____ Agency:_____

Address of person making referral: _____

Relationship to applicant: _____ Phone: _____ Fax:_____

Applicant's name: _____ Age: ____ Date of Birth: _____ Gender: M / F

Applicants Home Address: _____

Current address if differs from home address: _____

Applicants phone number: _____ Marital Status: M S W D Sep.

Social Security Number: _____-_____-_____

Type of admission: __ Voluntary __ Court Ordered * Please be aware this is not a locked facility, consumer may leave at any time*

Applicants Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

Does the applicant have health coverage: __ Yes __No

If yes, what type of health coverage? __ Private Insurance __Medicare __ Traditional Medicaid

__MCO Aetna __ MCO Beacon __MCO The Health Plan __ MCO Unicare

IT IS PREFERRED 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 seeking treatment? _____
_____
_____

What type of treatment are you seeking?

___Abstinence treatment, ___Suboxone Treatment, ___ Vivitrol Treatment

Please note at this time LEGENDS does not provide Suboxone treatment

Please describe you 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.

SUBSTANCE USE	FREQUENCY *Please circle correct frequency.*				AMOUNT	DATE OF LAST USE
Alcohol	Daily	3-5 times week	1-8 times month	Less than once per month		
Marijuana	Daily	3-5 times week	1-8 times month	Less than once per month		
Cocaine	Daily	3-5 times week	1-8 times month	Less than once per month		
Heroin	Daily	3-5 times week	1-8 times month	Less than once per month		
Opioids	Daily	3-5 times week	1-8 times month	Less than once per month		
PCP	Daily	3-5 times week	1-8 times month	Less than once per month		
LSD	Daily	3-5 times week	1-8 times month	Less than once per month		
Amphetamines	Daily	3-5 times week	1-8 times month	Less than once per month		
Benzodiazepines	Daily	3-5 times week	1-8 times month	Less than once per month		
Barbiturates	Daily	3-5 times week	1-8 times month	Less than once per month		
Inhalants	Daily	3-5 times week	1-8 times month	Less than once per month		
Other (specify)	Daily	3-5 times week	1-8 times month	Less than once per month		

What has been your longest period of abstinence in the past six months? _____

Have you used IV in the past six months? ___Yes ___ No

Have you ever been treated at LEGENDS or WAVES before? If yes when _____

Do you have family members currently being treated at LEGENDS and/or WAVES? ____ Yes ___ No

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

Are you capable of performing these tasks? ___Yes ___ No

What was the last grade of school completed? _____

Pregnancy

(Females only)

Are you on any forms of contraceptives ___Yes ___No

If yes, specify what kind and how long: _____

Are you pregnant? ___Yes ___No First day of last menstrual cycle _____

If yes what is your expected due date? _____ Who is your treating physician? _____

Treating Physician Phone Number: _____ Address: _____

Please note that any female that is pregnant requires a letter or statement from their physician stating they are medically cleared to attend treatment. All females will be given a pregnancy test upon admission

Medical

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

Please check all that apply. Please ensure to specify the physician treating the condition as well as any limitations.

✓	Condition	Physician	Comments
	High Blood Pressure		
	Difficulty Walking		
	Cirrhosis		
	GI Bleeding		
	Hepatitis		
	Coronary Artery Disease		
	Renal Failure		
	Liver Disease		
	Seizure Disorder		
	Blood Clots		
	Pancreatitis		
	Diabetes		
	Heart Problems		
	Inability to take oral medications		
	Tuberculosis		
	Breathing Problems		
	Headaches		
	Any other medical concerns		
	Teeth issues		

Please list any other medical provider(s) not listed:

_____

Have you ever been hospitalized for any of the above medical conditions? ___Yes ___ No

If yes, which conditions and when? _____

_____

_____

What medications are you currently taking? Please list all below.

_____

_____

_____

_____

_____

If admitted to LEGENDS or WAVES you must bring a 28-day supply of medications or refills for medications. You will not be transported to a doctor for any medication that you require on a daily basis. Controlled substances are not permitted. A physician must prescribe all medications. No OTC drugs are allowed unless a prescription is provided.

LEGAL

Are you facing legal charges? YES NO if yes, Note charges and give any upcoming court dates.

_____
_____
_____

Please note that LEGENDS and WAVES will not transport consumers to court dates while enrolled in the program

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, and contact information for PO.

_____
_____
_____

Mental Health

Have you ever been treated for any mental health conditions (depression, anxiety, bipolar, etc.) other than addiction? YES NO if Yes what type of mental health condition.

_____
_____
_____

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

_____
_____
_____

Do you have a history of suicide attempts or 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.

_____
_____
_____

Substance Use Related

When you have stopped using or drinking the past, have you experienced any of the following withdrawal symptoms?
____ Tremors ____Delirium Tremors ____Hallucinations ____Insomnia ____Seizures ____Sweats
____Agitation ____Irritability ____Nausea/Vomiting ____Mood Swings ____Black Outs ____Muscle Aches

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, Vivitrol, and Suboxone treatment.
YES NO. If yes, where, when, and how long were you clean after completing treatment?

_____
_____
_____

Have you ever been in an inpatient rehabilitation facility? YES NO If yes, where, 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?

_____
_____
_____

- LEGNEDS and WAVES are not medical facilities
- Please not that all applications must pass a drug screen and breathalyzer at the time of INTAKE; therefore, detox must occur prior to being admitted.

- During your stay at LEGENDS and WAVES, no passes or visitation (other than legal representatives) will be granted.

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.

All applicants will receive a letter or phone call in regards to their application status.

Please maintain weekly contact (if applicable) to inquire about your application/waitlist status. Note legal representatives can maintain your waitlist status. If accepted into another treatment facility please let LEGENDS and/or WAVES know to remove you from the waitlist.

Applicants Signature: _____ Date: _____

If you aided applicant in completing this application please sign below

_____ Date: _____

Relation: _____