FFCCSB RTDS PROGRAMMING
REGIONAL BED REFERRAL APPLICATION

Complete the below Referral Form and attach the following reports and information:

1. Comprehensive Assessment to include Psychosocial, Psychiatric, Family, Medical, Prior Treatment, and Substance Abuse Histories
2. Multidimensional assessment utilizing the ASAM criteria.
3. Hospital Admission and Discharge Summaries (Additional consents for release of information may be required)
4. Current Service Treatment Plan
5. Summary of Current Clinical Status and/or most recent Service Plan Review

**** Please note, failure to submit the above requested documents will delay consideration of your application.***

Email all documents to:
Augustine Aderiye
RTDS Residential Admissions Unit - BH Manager
Fax: 703-653-6684

Individual's Demographic Information

Individual's Name: _____ Social Security #: _____
Date of Birth: _____ Gender: _____

Address: _____
Phone Number: _____ Alternative #: _____

Regional Referral Contact Information

Name: _____ Title: _____
Address: _____
Office Phone: _____ Fax: _____
Email address: _____ Alternative #: _____

Supervisor: _____ Title: _____
Office Phone: _____ Fax: _____
Email address: _____ Alternative #: _____

Other Agencies/Professionals Involved (e.g. Legal, Financial, Housing, etc.)

Name: _____ Agency: _____
Phone Number: _____ Fax: _____
Email address: _____ Alternative #: _____

Name: _____ Agency: _____
Phone Number: _____ Fax: _____
Email address: _____ Alternative #: _____

Name: _____ Agency: _____
Phone Number: _____ Fax: _____
Email address: _____ Alternative #: _____

Reason for Referral

Presenting Problem(s):
Please also include description in individual's own words of need for service

_____
_____
_____
_____
_____

Signs and Symptoms of Decompensation/Relapse
Please also include description in individual's own words of signs, symptoms, and behaviors

_____
_____
_____
_____
_____

Psychiatric and Medical Information

Current Diagnosis Problem List:
Problem 1: _____
Problem 2: _____
Problem 3: _____
Problem 4: _____

Prescriber/Psychiatrist Name: _____
Date of most recent medication appt: _____
Address: _____
Office Phone: _____ Fax: _____
Email address: _____ Alternative #: _____

Primary Care Physician/clinic: _____
Date of most recent comprehensive physical: _____
Address: _____
Office Phone: _____ Fax: _____
Email address: _____ Alternative #: _____

Health Insurance
Medicaid? ☐ Yes ☐ No Name of MCO: _____
Medicare? ☐ Yes ☐ No Name of Part D (prescription) plan: _____
Private Insurance? ☐ Yes ☐ No Name: _____

Current Psychiatric Medications

1. Name: _____ Dosage: _____ Frequency: _____
2. Name: _____ Dosage: _____ Frequency: _____
3. Name: _____ Dosage: _____ Frequency: _____
4. Name: _____ Dosage: _____ Frequency: _____

Current non-Psychiatric Medications

1. Name: _____ Dosage: _____ Frequency: _____
2. Name: _____ Dosage: _____ Frequency: _____
3. Name: _____ Dosage: _____ Frequency: _____
4. Name: _____ Dosage: _____ Frequency: _____

Plan for securing/paying for prescribed medications

Comments: _____

Compliance with medication? Requires prompting/monitoring?

Comments: _____

Side effects from prescribed medications? Adverse effects?

Comments: _____

Risk Assessment

Self-abuse/self-harm:

☐ N/A – No current or past self-harm behaviors ☐ Refused to provide information

Comments: _____

Suicidal Ideation and Attempts:

☐ N/A – No current or past suicidal ideation or attempts ☐ Refused to provide information

Comments: _____

Homicidal/Assaultive Ideation and acts, including Verbal and Physical Aggression:

☐ N/A – No current or past homicidal ideation/assault/aggression ☐ Refused to provide information

Comments: _____

History of Fire Setting:

☐ N/A – No history of fire setting ☐ Refused to provide information
Comments: _____
_____
_____

History of Psychiatric hospitalizations:
☐ N/A – No history of psychiatric hospitalizations ☐ Refused to provide information

If recent, include name of hospital and dates of admission below
1. _____
2. _____

Comments: _____
_____
_____

Please answer yes or no to the following:

1. Denies addiction/substance use problems	☐ Yes	☐ No
2. Denies mental illness symptoms	☐ Yes	☐ No
3. At risk due to relapse/overdose	☐ Yes	☐ No
4. At risk due to self-neglect (e.g. not eating)	☐ Yes	☐ No
5. At risk due to victimization (e.g. domestic violence)	☐ Yes	☐ No
6. At risk due to poor impulse control/high-risk behaviors	☐ Yes	☐ No

Comments: _____
_____
_____

Substance Abuse Profile

1. Primary Substance: _____
Age of 1st Use: _____ Age of Onset of Regular Use: _____
Date of Last use: _____ Recent frequency of Use: _____
Quantity: _____ Method of Use: _____

2. Secondary Substance: _____
Age of 1st Use: _____ Age of Onset of Regular Use: _____
Date of Last use: _____ Recent frequency of Use: _____
Quantity: _____ Method of Use: _____

3. Tertiary Substance: _____
Age of 1st Use: _____ Age of Onset of Regular Use: _____
Date of Last use: _____ Recent frequency of Use: _____
Quantity: _____ Method of Use: _____

Additional Substance Use History:

Comments: _____
_____
_____

Acute Intoxication/Withdrawal Potential:

☐ N/A – No current intoxication or withdrawal potential ☐ Refused to provide information

Comments: _____
_____
_____

Current or Past episodes of Abstinence:

☐ N/A – No current or history of abstinence ☐ Refused to provide information

Comments: _____
_____
_____

Current or Past Substance Use Treatment Services:

☐ N/A – No current or history of SUD treatment ☐ Refused to provide information

Please describe prior substance use treatment experience and outcomes. Does not include detoxification services.

Comments: _____
_____
_____

Current or Past Mental Health Treatment Services

☐ N/A – No current or history of MH treatment ☐ Refused to provide information

Please describe prior mental health treatment experience and outcomes.

Comments: _____
_____
_____

Current or Past Residential Treatment Services

☐ N/A – No current or history in residential treatment setting ☐ Refused to provide information

Please describe prior residential treatment experience and outcomes. Does not include hospitalizations or crisis stabilization services.

Comments: _____
_____
_____

Current or Past Criminal Charges

☐ N/A – No history of legal charges/involvement ☐ Refused to provide information

Please describe any past or current legal charges, probation status, involvement with special docket, Not Guilty by Reason of Insanity (NGRI) status?

Comments: _____
_____
_____

Probation/Parole Officer:

Name: _____ Agency: _____

Phone Number: _____ Fax: _____
Email address: _____ Alternative #: _____

Income/Financial Resources

Current Monthly Income: _____
Source(s) of Income (SSI, SSDI, General Relief, Employment): _____

Representative Payee or other support (family/friend) who manages funds? ☐ Yes ☐ No
Name: _____ Agency: _____
Phone Number: _____ Fax: _____
Email address: _____ Alternative #: _____

Comments: _____
_____
_____

Day Structure/Recovery Activities

Current Daytime Activity/Employment:
☐ N/A – No current or past daytime activities ☐ Refused to provide information
Comments: _____
_____
_____

Past or Current Involvement with 12-Step or other Recovery Supports:
☐ N/A – No current or past 12-Step/Recovery Supports ☐ Refused to provide information
Comments: _____
_____
_____

Social Supports (e.g. Family/Significant Other, Friends, Social Groups, Religious Affiliation):
☐ N/A – No current or past Social Supports ☐ Refused to provide information
Comments: _____
_____
_____

Housing and Basic Living Skills

Housing
Homelessness: ☐ Never ☐ Past ☐ Currently ☐ Imminent/At Risk
Current Housing: ☐ On own/Permanent ☐ Family/Social support ☐ Recovery housing
Comments: _____
_____
_____

Housing plan at time of Discharge: _____

_____

_____

_____

Independent Living Skills

In collaboration with individual (if possible), please rate the individual's skills in the following areas:

Personal Hygiene	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Laundry	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Waking in AM	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Med Adherence	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Nutrition	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Cooking	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
House Cleaning	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Budgeting	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Grocery Shopping	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent
Public Transportation	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Excellent

Comments: _____

_____

_____

ASAM Assessment

Dimension 1 – Intoxication, Withdrawal, & Potential Risk

Risk Rating: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4

Comments: _____

_____

_____

_____

Dimension 2 – Physical/Medical Issues

Risk Rating: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4

Comments: _____

_____

_____

_____

Dimension 3 – Emotional, Behavioral, Cognitive Issues

Risk Rating: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4

Comments: _____

_____

Dimension 4 – Stage of Change/Readiness

Risk Rating: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4

Comments:

Dimension 5 – Relapse/Continued Problem potential

Risk Rating: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4

Comments:

Dimension 6 – Recovery Environment/Supports

Risk Rating: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4

Comments:

Other Clinically Significant Information

Strengths:

Weaknesses:

Goals for residential treatment placement in individual's own words:

Other specific areas of concern: