

GARCIA HOUSE

A CIRCLE PROGRAM BY SUMMITSTONE



REFERRAL INFORMATION

Thank you for considering Garcia House as a treatment provider. For us to accurately assess our ability to meet you or your client's needs, please thoroughly complete this application. Missing information may delay our review process.

If you need any assistance in completing this application or have any questions, please contact: (970) 494-5729.

Completed referrals can be sent to garciahouser referrals@summitstonehealth.org

Referral Checklist

- Completed admission questionnaire

Please provide all that are available:

- Substance use treatment and diagnosis records
- ASAM assessment
- Mental health treatment and diagnosis records
- Medical treatment and diagnosis records
- Recent hospital/ER visit records
- Court/legal documentation
- Current prescription orders (type, dose, frequency)
- Copy of insurance card

ADMISSION QUESTIONNAIRE

Please Print Legibly

If you are being referred by another agency (DHS, Probation, Parole, Detox, Hospital, etc.), please ask for their assistance in completing this form. If you are not being referred by another agency and would like assistance filling this form out, please contact (970) 494-5729.

Today's date: _____

Name: _____

Date of birth: _____

Gender: Male Female Transgender - Male to Female Transgender - Female to Male
 Gender variant Agender Other _____

Garcia House works to offer housing for all identified genders. Please note your preference for room assignment.

I prefer to be placed with the following identified gender: Male Female Other _____

REFERRAL SOURCE

Name: _____ Agency: _____

Phone: _____ Address: _____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ Relationship: _____

Phone: _____ OK to leave message: Yes No

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INSURANCE:

Insurance: Medicare Yes No Medicaid Yes No SSI Yes No

SSDI Yes No Private Insurance Yes No Private Pay Yes No

Other: _____

Member number (on insurance card): _____

Name of insurance policyholder: _____

Phone: _____ Address: _____

CLIENT DEMOGRAPHIC INFORMATION:

Social security number: _____

Phone: _____

OK to leave message: YES NO

Physical address: _____

City: _____ State: _____ Zip: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Number of people in household: _____

Pregnant: Yes No Due date (if applicable): _____

How many children, under the age of 18, are in your custody: _____

Living status: Independent Correctional facility Sober living Nursing home
 Group home Halfway house Homeless (no fixed address - includes shelters)
 Treatment facility (residential/inpatient/ATU, etc.): _____

Marital status: Single (never married) Married Widowed Separated Divorced

Source of income: Wages Public assistance Retirement/pension Disability
 None Other: _____

Employment status: _____ Occupation: _____

Number of days worked in the last 30 days: _____ Annual income: _____

Highest level of education: _____

Admission status (check one):
 Voluntary DHS Involuntary commitment Condition of probation/parole/pretrial

CRIMINAL JUSTICE INFORMATION (IF APPLICABLE)

Registered sex offender: Yes No

Currently participating in sex offender treatment: Yes No

If yes, please send documentation of sex offender treatment.

Currently under sex offender supervision? Yes No

If you are currently under any legal supervision, upon admission, you will be required to sign a release of information for the supervising agency

Pending charges: Yes No If yes, explain: _____

Probation/parole officer's name, state, and county and contact information (if applicable):

Current criminal charges: _____

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Substance use history:

| Substance | Frequency of use | Amount used | Method of use (oral, nasal, IV, smoke) | Date of last use | Longest length of sobriety | History of Withdrawal – if yes describe what happened |
|---|------------------|-------------|--|------------------|----------------------------|---|
| Alcohol | | | | | | |
| Cocaine/crack | | | | | | |
| Marijuana | | | | | | |
| Stimulants, Methamphetamine, Amphetamines | | | | | | |
| Heroin | | | | | | |
| Opiates (Morphine, OxyContin, Fentanyl, Percocet, etc.) | | | | | | |
| Hallucinogens (MDMA, Mushrooms, Ecstasy, PCP) | | | | | | |
| Tranquilizers, Benzodiazepines or Sleep Aids (Xanax, Valium, Ativan, Ketamine, Ambien, Sonata, Lunesta) | | | | | | |
| Inhalants | | | | | | |
| Nicotine | | | | | | |
| Other (bath salts, spice, Kratom): _____ | | | | | | |

Have you ever been diagnosed with a Substance Use Disorder or Mental Health Disorder?

Yes No

If yes, please list diagnoses and approximate dates of diagnosis:

| Date | Diagnosis |
|------|-----------|
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Please explain any other problematic areas of your life (gambling, eating disorder, shopping, etc.):

Have you previously attended psychiatric or substance use treatment? Yes No

If yes, please list facility name and dates of treatment:

| Dates of treatment | Facility |
|--------------------|----------|
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Medical history: Please list any past or current medical conditions/diagnoses:

| Past/Current | Medical conditions/diagnoses |
|--------------|------------------------------|
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List all current medications and dosages:

| Medication | Dosage |
|------------|--------|
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List any medical durable equipment (oxygen, C-pap, Glucometer, etc.):

| Medical durable equipment |
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Please list any dietary needs or food allergies:

| Dietary/Allergy | Type |
|-----------------|------|
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ANY MISREPRESENTATION OF INFORMATION MAY RESULT IN DENIAL OF ADMISSION

Client Signature

Date

Person completing application, if other than client: _____