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 garciahousereferrals@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 (including guardianship documents)

☐ Current prescription orders (type, dose, frequency)

☐ Copy of insurance card

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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

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: _____

Do you have a legal guardian or medical decision maker? ☐ Yes ☐ No **If yes, please provide court documents**

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

If the individual is incarcerated <u>at the time of referral</u>, are they eligible to be bonded out for treatment when a bed becomes available? ☐ Yes ☐ No If yes, date available to admit: _____

<u>CRIMINAL JUSTICE INFORMATION (IF APPLICABLE)</u>

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: _____

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

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

Medical history: Please list any past or current medical conditions/diagnoses:

Past/Current	Medical conditions/diagnoses

Please provide the names and contact details, if available, of all healthcare providers you are currently seeing, including those for physical and mental health:

Name	Contact information (phone, address or medical group)

List all current medications and dosages:

Medication	Dosage

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

Medical durable equipment

Please list any dietary needs or food allergies:

Dietary/Allergy	Type

ANY MISREPRESENTATION OF INFORMATION MAY RESULT IN DENIAL OF ADMISSION

_____

Client Signature Date

Person completing application, if other than client: _____