**Referral Form**

**(to be completed by the client’s Case Manager)**

|  |  |  |
| --- | --- | --- |
| **Client Information:** | | |
| **Name:** | Phone #: (     )-     - | Email: |
| Age: | Gender: |  |
| Last known address: | | If homeless, how long: |
| Has client participated in Granada House program before: | | Client is over 18: |
| Client is mentally and physically stable and does not pose risk to self or others: | | Client is substance free for at least five days: |
| Client is able to participate in Granada House Individual and Group Treatment programs and abide by house rules: | | Client is not actively infected by TB: |
| Client has no personal circumstance/obligations preventing him or her from fulfilling treatment expectations (i.e: work, attend groups, curfew, chores etc.): | | Client is medically cleared per ASAM Dimension 1.: |
| Registered sex offender or pending charge that may result in registered status: | | Client has consented to referral to Granada House: |
| **Case Manager Information:** | | |
| Case Mgr Name: | Phone#: (     )-     - | Email: |
| Agency: | Supervisor: | Supervisor Phone:(     )-     - |
| **Client Family History:** | | |
| Marital Status: Married: , Divorced: , Separated: , Single: , Widowed: | | History of violence in relationship: |
| Restraining order: | Partner’s substance use history: | |
| Children? If yes, how many: | Client has legal  physical custody  of children? | Is DCF involved with children: |
| Parental Substance Abuse, if any: | | |
| **Educational History:** | | |
| Highest level completed: | Vocational Training: | Learning disability: |
| **Legal:** | | |
| Outstanding warrants: | Pending Case/s: | Any legal obligations that may compromise treatment: |
| Status of pending case/s: | | |
| Parole/Probation officer/court: | | Phone: (     )-     - |
| Gang affiliations past/present: | | |
| **Mental Health & Medical History/Current Status:** | | |
| Mental Diagnosis, if any: | History of Mental Health Treatment:  Outpatient  Inpatient  Residential | |
| Reasons why mental health treatment sought: | | |
| Suicide attempts/ideations: | Explain self harm history: | |
| Trauma History: | | |
| Current Therapist/Clinic: | | Phone: (     )-     - |
| Psychiatrist/Clinic: | | Phone: (     )-     - |
| Medical History/current diagnosis: | | Current medical treatment: |
| **Current Medications (not including MAT):** | | |
| **Medication** | **Dosage** | **Provider/phone** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Substance Use & Treatment History:** | | |
| Date current treatment began: | Expected completion Date: | Placement prior to current: |
| Primary Substance Choice: | | Frequency: |
| Number of years of active use: | Age at first use: | First substance used: |
| Longest substance free period: | When: | Date of last use: |
| **History of Substance Use Treatment:** | | |
| # of Detox: | Where: | When: |
| # of TSS: | Where: | When: |
| # of CSS: | Where: | When: |
| # of Recovery homes: | Where: | When: |
| # of Sober homes: | Where: | When: |
| Any other addictive behaviors: |  |  |
| Are you currently on MAT (Medication Assisted Treatment: . If yes, complete the following: | | |
| Methadone | Dosage: | Provider/phone: |
| Suboxone | Dosage: | Provider/phone: |
| Naltrexone | Dosage: | Provider/phone: |
| Other: | Dosage: | Provider/phone: |
| **Insurance: (check all that apply)** | | |
| Medicaid/MassHealth | Medicare (age 65 or disabled) | OT/State Subsidy (Health Safety Net/Commonwealth Care etc.) |
| HMO (employer/self pay) | Uninsured | Application pending |
| Insurance Company: | | Policy Name: |
| Policy #: | | Group #: |
| **Current Source of Income: (Check all that apply)** | | |
| Wages/Salary | Alimony | Child Support |
| VA Pension | Public Assistance - AFDC | Cash Income |
| Disability (SSI) | Disability (SSDI) | Disability (Veterans) |
| Workers Comp | Social Security | Unemployment |
| Other/describe: |  | None |
| Total Client Income:      Weekly Monthly | | Assets: |
| **Additional comments, if any:** | | |
| **For rapid consideration, please attach the following (if any) with your referral:** | | |
| Bio-Psych-Social Assessments | Current Treatment plan | TB Screening/Assessment |
| **Intake Process:** |  |  |
| Client’s Case Manager will send this referral form with attachments to Granada House by email: [referrals@granadahouse.org](mailto:referrals@granadahouse.org) or by fax (617)787-3820 | | |
| Granada House Clinical Director will review the referral form and, if necessary ask for additional documents by email or a phone call | | |
| If deemed appropriate for placement, the Case Manager/Client will be informed that the client is placed on Granada House Wait list | | |
| After placed on the Wait list, the client is to check-in daily by calling our main line (617)254-2923 and leave a message | | |
| When space becomes available, Client/Case Manager will be informed of the date/time of intake | | |
| **What a Client needs to bring when admitted to Granada House** | | |
| Supple of medications (prefer 30 days) | Only **two** bags of clothing (no suitcases) | Toiletries |
| For any questions, please call our main line and select the option to speak with appropriate staff. | | |