**Referral Form**

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

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| **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** |
|       |       |       |
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| **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 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. |