**Brooks- TLC Hospital System, Inc.**
Inpatient Chemical Dependency
845 RT 5&20 Main Road
Irving, NY 14081

# INPATIENT CHEMICAL DEPENDENCY

# REFERRAL PACKET

**LORI DARLING**

**ADMISSIONS/INTAKE**

**EMAIL: cdadmissions@tlchealth.org**

**PHONE: 716-951-7948**

**FAX: 716-951-7946**

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## BROOKS-TLC HOSPITAL SYSTEM, INC. INPATIENT CHEMICAL DEPENDENCY SERVICES

Thank you for your interest in the Inpatient Chemical Dependency Program. To initiate a referral, please complete the application and have the patient complete the Patient Questionnaire. When completed, fax all the requested information to 716-951-7946, attention admissions. If you have any questions regarding the admission process, please call 716-951-7948 to speak directly to the admissions office.

## PROGRAM INFORMATION

The Inpatient Chemical Dependency Unit is a 20 bed co-ed unit for individuals age 18 or older who have a substance abuse disorder. Patients receive comprehensive, integrated inpatient therapy from a multi-disciplinary team. This team includes; psychiatrist, nurse practitioner, certified addictions counselors, registered nurses, case managers, social worker and support staff.

The program provides individual, group, and family therapy through an individualized treatment program in which aftercare planning and referral involvement are key components.

Patients participate in structured groups daily ranging in intensity from educational/didactic groups to recreational therapy. Also, patients receive individual sessions with addictions counselors. Trauma informed treatment is aimed at assisting our patients with the achievement of life-long recovery, self-sufficiency, and personal success using evidenced based practices.

## Included in this packet:

- Referral application (to be completed by referral source)
- Patient Questionnaire (to be completed by prospective patient)
- Program information for prospective patients
- Patient handbook
- Family and friend information (visiting, patient phone numbers, and mailing address)
- Program schedule
- Releases

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# INPATIENT CHEMICAL DEPENDENCY SERVICES

## REFERRAL PACKET

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|---|---|
| **TO:** | **FROM: LORI DARLING, ADM. COORDINATOR** |
| **CONTACT #:** | **CONTACT #: 716-951-7000 X 7948** |
| **FAX:** | **FAX: 716-951-7946 or 716-951-7947** |
| **EMAIL:** | **EMAIL: cdadmissions@tlchealth.org** |

Referring provider:

Please check off the information below verifying that you are sending a complete referral packet. Sending all the information below will help process the referral quicker.

- ○ Referral application (to be completed by the referring provider. (Please be sure all insurance information is provided otherwise this will hold up the referral process)
- ○ Patient Questionnaire (to be completed by the patient)
- ○ Medication list

**Confidential Health Information** Health care information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

**Important Warning:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message.

## REFERRAL APPLICATION (to be completed by referring provider)

**DEMOGRAPHIC**

Date: _____ Has the patient been admitted to our facility previously? Y N

Name: (Last) _____(First)_____M.I._____

Address:_____ D.O.B. _____

_____ S.S.# _____

Phone: (_____)_____ Ethnicity: _____

Will he/she return to the above address when discharged from our program? _____Y _____N

If not, where will he/she live? (**Patient must have a permanent residence prior to admission.** If a halfway house referral has been started please be sure to document where and when. Additionally Public Assistance/Cash Assistance needs to be established prior to a halfway house) _____

_____

How will the patient be transported to our facility? _____

Referral source/Name and Agency _____

Contact Person: _____

Address: _____

Phone: (____)_____Fax (____)_____

**SUBSTANCE ABUSE CLINICAL DIAGNOSES**

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

| Substance used | Age of first use | Date of last use | Amount typically used | Frequency of use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Does the patient see an outpatient Mental Health Counselor and/or Psychiatrist?

Name: _____ Phone: (____)_____

Address: _____

Does the patient see an Outpatient Chemical Dependency Counselor?

Name: _____ Phone: (____)_____

Address: _____

**MEDICAL**

**Please list all medications that the patient is taking currently or include medication list**

Medication Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy : Phone: ( )

*Certain medications must be brought in upon admission, i.e., Interferon, HIV, Cardiac, Inhalers, Birth control, Topical creams, etc.*

Medical Problems

_____

_____

**PLEASE NOTE* IF THERE ARE CURRENT/ACTIVE MEDICAL PROBLEMS THEY MUST BE TREATED PRIOR TO ADMISSION TO OUR PROGRAM.**

Allergies: _____

Primary Care Physician: _____Phone: (___)_____

Any scheduled medical appointments? ____Y____N If yes, when? _____

Any history of self-injurious behavior? ____Y____N If yes, when? _____

Any history of suicide attempts? ____Y____N If yes, when? _____

Please indicate incidents, degree, method, frequency, etc.: _____

_____

Any history of psychosis? (command hallucinations) ____Y____N If yes, When? _____

Any history of Mania? ____Y____N If yes, when? _____

Any history of Inpatient Mental Health? ____Y____N If yes, When? _____

Any history of commitment to a State Mental Health facility?

____Y____N If yes, when? _____

**We must be notified of any changes in a physical status, mental status, medical problems or self-injurious behaviors prior to admission.**

**LEGAL HISTORY**

Probation/Parole? ____Y____N Scheduled court date(s)_____

Court Mandated? ____Y____N By whom? _____

Currently a sex offender Under Megan's Law? ____Y____N What level? _____

Any history of violence, arson, or sexual assaults? ____Y____N If yes, Which one? And When?

_____

_____

Descriptions of arrests/charges and disposition_____

_____

Name of Probation/Parole Officer: _____Phone: (____)_____

County of Probation/Address _____

**INSURANCE COVERAGE (PATIENT MUST HAVE ACTIVE INSURANCE PRIOR TO ADMISSION)**

_____ MEDICAID: _____(CN#) _____(SEQUENCE #)

_____MEDICARE A&B _____

Has the patient been hospitalized in the past 60 days? ____Y____N If yes, where?_____

_____COMMERCIAL INSURANCE _____EMPLOYER_____

ID# _____ _____PHONE # _____

COVERAGE UNDER WHOSE NAME? _____

(If not in the patient's name, give subscriber's name, social security #, and place of employment)

**PLEASE NOTE***IF THE PATIENT HAS COMMERCIAL INSURANCE OR A MANAGED CARE MEDICAID INSURANCE PROVIDER, IT IS THE RESPONSIBILITY OF THE REFERRAL SOURCE TO OBTAIN THE AUTHORIZATION AS YOU ARE THE TREATING FACILITY RECOMMENDING THIS LEVEL OF CARE.**

**ADMISSION CRITERA** ****PLEASE READ**** **(to be completed/signed by referral source)**

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_____ **Must be 18 years of age or above**

_____ **Current substance abuse diagnosis**

_____ **Meets criteria for inpatient substance abuse treatment under the American Society for Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R)**

_____ **Psychiatric symptoms must be stabilized and must not warrant admission at a different level of care (i.e. Inpatient psychiatric treatment) or will not potentially interfere with patient's participation in treatment at our program.**

_____ **Medical problems must be stabilized and must not interfere with the patient's participation in the treatment program.**

_____ **Must have a form of payment (we accept most commercial insurances, Medicare, New York State Medicaid or private pay)**

_____ **While we make referrals to residential programs for our patients, the patient should have permanent housing prior to their admission. If this is not in place, homeless shelters will be utilized as appropriate housing upon discharge.**

_____ **Patient may be withdrawn from addictive or potentially addictive substances if historically abused. Methadone and buprenorphine are allowed but the patient must already have a prescription and these medications should be prescribed for opiate maintenance therapy only. Additionally, they must be able to return to their prescriber otherwise it will be discontinued before discharge. Patient may begin MAT if recommended only with collaboration with community based provider for maintenance.**

_____ **Our program is voluntary. The patient must consent to treatment and must agree to follow all program rules and routines.**

_____ **The patient must be capable of functioning within the program. They must have at least a minimal ability to read and write, and their cognitive functioning should not impede their ability to progress within the treatment program.**

**The statements above are true and accurate as reported by me. I have read the admissions criteria and understand that if the patient arrives to treatment and they are not appropriate they will be discharged.**

**Name/signature referral source**_____ **Date:**_____

## PATIENT QUESTIONNAIRE (to be completed by prospective patient)

Name: _____

**MEDICAL**

Do you require dental care? ____Y____N

If you wear glasses, do you have them? ____Y____N

Do you have an eating disorder? ____Y____N

Are you currently pregnant or have a chance of being pregnant? ____Y____N

Do you require any treatment from an OB/GYN at this time? ____Y____N

Are you taking all medications as prescribed by your physician? ____Y____N

*If you are taking the following medications you will need to bring them to treatment. Any heart medications, HIV, Birth control, Inhalers, Interferon, or topical medications*

Are you having any suicidal/homicidal thoughts? ____Y____N

Have you had suicide attempts? ____Y____N

If yes, when? _____

Do you have any current medical problems? ____Y____N

If yes, please comment :_____

_____

Will any of these illnesses or conditions interfere with your treatment? ____Y____N

Are you experiencing pain that will interfere with your treatment? ____Y____N

Do you feel that you are medically stable to complete treatment at this time? ____Y____N

Other comments: _____

**LEGAL/MANDATE**

Are you mandated to treatment? ____Y____N

If yes, by whom?_____

Do you have a history of violence, arson, or sexually acting out? ____Y____N

If yes, please explain: _____

_____

**PROGRAM**

The Inpatient Chemical Dependency Program is very intensive. Groups begin early in the morning and end late in the evening. There are groups all day long and all of them are mandatory. Are you aware that you must attend and participate in all groups? ____Y____N

All items will be searched upon admission. Patients will be given a gown for cover while clothing and shoes are searched. Are you aware of the search upon admission? ____Y____N

Did you read and understand the Patient Handbook addressing the rules and general information or the program prior to admission? ____Y____N

**POST DISCHARGE**

Do you have a place to return to live? ____Y____N

Are you aware of our aftercare recommendations? ____Y____N

(Appointment for outpatient drug and alcohol counseling, attending AA/NA meetings and getting a sponsor)

**MOTIVATION**

On the following scale, please rate your motivation for treatment at this time: Circle one

1 2 3 4 5 6 7 8 9 10

**Poor** **Excellent**

Please describe why you feel you need or want treatment at this time: _____

_____

**TREATMENT AGREEMENT**

By signing below, you agree to the following;

I have read and understand the information provided in the Patient Handbook and agree to abide by these rules. I have also been given the opportunity to ask questions regarding the program rules and I am fully aware of what is expected while I am in treatment.

Patient signature: _____Date_____

Witness signature: _____ Date: _____