Lifeline Connections

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Admissions Referral Form-Residential Services Only

Complete this document and submit with a full ASAM Assessment.
Fax: (360) 397-8455 / Email: admissions@lifelineconnections.org (please encrypt)
This document must be received before a client will be scheduled.

Choose the Lifeline SUD Residential program you are referring your patient to:

☐3.5 Men's Residential ☐3.1 Men's Low Intensity
☐3.5 Women's Residential ☐3.3 Women's PPW Residential

PATIENT INFORMATION			
Name	**(Last)**	**(M)**	**(First)**
Preferred Name:			
Phone:	**Optional Phone#**	**OK do ID?** ☐YES ☐NO	
Physical Address:			
City:	**State:**	**Zip Code:**	
Mailing Address: (if different)			
Email Address:			

ADDITIONAL DEMOGRAPHICS	
Date of Birth:	**Social Security #:**
If no Social Security #, please explain:	
Gender: ☐Male ☐Female (for insurance purpose these are the only choices)	
Preferred Pronoun: ☐He/His/Him ☐She/Her/Hers ☐They/Them/Theirs	
Sexual Orientation: ☐Choosing not to disclose ☐Bisexual ☐Gay/Lesbian/Homosexual ☐Heterosexual/Straight ☐Questioning	
Gender Identity: ☐Female ☐Male ☐Non-Binary ☐Intersex (state identified option) ☐Transgender female ☐Transgender mal e ☐Unknown ☐Choosing not to disclose	
Are you Pregnant: ☐Yes ☐No ☐Not Applicable	☐Unknown Due Date:
Race: (choose all that apply and circle your primary race) ☐Alaska Native/ American Indian ☐Asian Indian ☐Black/African American ☐Native American ☐Non-federal tribe ☐Other Asian ☐Other Pacific Islander ☐Other race ____________________ ☐White/European	
Ethnicity: (choose one ☐Cuban ☐Mexican/Mexican American/Chicano ☐Not Spanish/Hispanic/Latino ☐Other Spanish /Hispanic/Latino ☐Puerto Rican ☐Refused to Answer ☐Other: ____	

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Living Status: (choose one) ☐Independent Living (Adult) ☐Dependent Living (Adult) ☐Crisis Residence ☐Homeless ☐Homeless with housing ☐Institutional Setting ☐Jail/Correctional Facility ☐Other Residential Status ☐Residential Care ☐Foster Home / Foster Care ☐Private Residence (Child)

Marital Status: (choose one) ☐Divorced ☐Married/Committed Relationship ☐Never married/Single ☐Separated ☐Widowed ☐Other:______________________________

Smoking Status: (choose one) ☐Current Smoker ☐Former Smoker ☐Never Smoked ☐Refused to Answer/ Unknown

Preferred Language: (choose one) ☐American Sign Language ☐English ☐Romanian ☐Russian ☐Spanish ☐Ukrainian ☐ Unknown Other Language: _____________________________________

Need Interpreter? ☐Yes ☐No

Have you ever served in the military? ☐Yes ☐No ☐ Refused to answer

EMPLOYMENT INFORMATION Employment status (circle one): ☐Full Time ☐Part Time (less than 30 hours) ☐Not Working Due to Disability ☐Retired ☐Student ☐Unemployed, seeking work ☐Unemployed, not seeking work ☐Underage/Not in Workforce ☐Other

EDUCATION INFORMATION Highest Level Completed: ☐High School Diploma ☐GED ☐Grade12 ☐AA ☐Vocational Training ☐Some College ☐bachelor's degree ☐Graduate or professional school ☐Unknown ☐Other:____

Have you attended school in the last 3 months: ☐Yes ☐No

Referral Source: ☐Court/Criminal ☐Hospital ☐MH Provider ☐SUD Provider ☐Self/Family ☐Healthcare Provider ☐Other Community Referral - Agency Name: ____

HOUSEHOLD INFORMATION Annual Household Income: $__________
Number of Individuals in your Household: ______ How many are under the age of 18:____
Source of Household Income (choose all that apply): ☐Wages/Salary ☐Public Assistance ☐Disability Benefits ☐Retirement/Pension ☐Other ____ ☐None

ADDITIONAL MEDICAL INFORMATION

Are you on (MAT) Medicated Assisted Treatment: ☐ Yes ☐ No
☐Suboxone ☐Methadone --- If yes, to Methadone do you have courtesy dosing arranged ☐Yes ☐ No
(You must bring a 30-day supply of your MAT medication.)

Do you have an ROI for your MAT provider? ☐Yes ☐ No

Do you currently have diabetes? ☐ Yes ☐ No
If yes, MUST bring all meds, including insulin, blood glucose monitoring kit and test strips.

Are you capable of self-care? (Eating, walking, dressing, showering, and transferring if in wheelchair) ☐Yes ☐ No

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Do you have a history of seizures? ☐ Yes ☐ No

*If yes, are you on medications to control seizures? ☐ Yes ☐ No

*Are you diagnosed with a seizure disorder? ☐ Yes ☐ No

*When was your last seizure and how often? ____

Do you have a history of a heart condition? ☐ Yes ☐ No
* If yes, are you currently taking medications for your condition? ☐ Yes ☐ No
* If no, should you be taking medications for it? ☐ Yes ☐ No

*What is the condition? ____

Will your biomedical conditions interfere with treatment programming? ☐Yes ☐ No

Are you able to bring 30-day supply of all your bio medical medications if applicable? ☐Yes ☐ No

Are you able to bring a 30-day supply of all your mental health medications if applicable? ☐Yes ☐ No

Are you a registered sex offender? ☐ Yes ☐ No if yes, what level _________ Do you have restrictions? ☐ Yes ☐ No

Do you have a history of aggressive behaviors? ☐ Yes ☐ No If yes, do you currently have any pending charges related to assaultive behaviors? ☐ Yes ☐ No If no, when if applicable was your last charge?

Please explain details:

I understand that by signing this document, I am verifying that the information presented on the document is accurate.
May be signed by patient or referring agency.

Signature:	Date:

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Health Assessment for Residential Services

Name:	Date:
Medical Health History - Medical conditions the patient has currently or has experienced in the past year:	
☐ Allergies: (List)	

☐ Anemia or blood disorder	☐ Anorexia/Bulimia	☐ Arthritis
☐ Asthma	☐ Bowel/bladder conditions	☐ Cancer
☐ Chest pains	☐ Circulation disorders	☐ Concussion/head trauma
☐ Diabetes	☐ Dizziness/fainting spells	☐ Heart disease
☐ Hepatitis	☐ Stroke	☐ TB
☐ Bone/Joint Problem	☐ Liver Disease	☐ Seizures
☐ Vision Problems	☐ Muscle Pain	☐ Headaches
☐ Hearing Problems	☐ Kidney disease	☐ Oral Health
☐ Thyroid Problems	☐ Sexually Transmitted Disease	

☐ Other:

Additional medical comments:

Health Assessment for Residential Services

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General: (E.g. Weight loss/gain, fatigue, fever/chills, weakness)
Ear, Nose, Mouth, and Throat: (E.g., Difficulty hearing, mouth sores, ear pain, sore throat, facial pain/numbness)
Cardiovascular: (E.g. Irregular heartbeat, chest pains, edema)
Respiratory: (E.g. SOB, night sweats, coughing up blood, abnormal chest x-ray)
Gastrointestinal: (E.g. Painful urination, blood in urine, GU disorders, LMP)
Musculoskeletal: (E.g. Joint pain, swelling of the joints, redness of joints)
Integumentary: (E.g. Persistent rash, skin lesion, hair loss/increase, sores, breast changes)
Neurologic: (E.g. Frequent headaches, double vision, problems with walking or balance, uncontrolled motion)
Hematologic: (E.g. Easy bleeding, anemia, easy bruising)
Endocrinologic: (E.g. Intolerance to heat or cold, menstrual irregularities)
Allergic/Immunologic: (E.g. seasonal allergies, allergies to medicine/food/latex)

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Health Assessment for Residential Services

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List of Medications:

Recommendations:

____

Printed Practitioner/Nurse

____

Date

____

Practitioner/Nurse Signature