# MAP BEHAVIORAL HEALTH
## REFERRAL FORM

**66 Burnett Street Providence, RI 02907**
**(Phone) 401-785-0050 ext. 10 (Fax) 401-941-0089**

**PLEASE READ BEFORE SENDING ANY REFERRAL TO ENSURE A TIMELY AND ACCUARTE REFFERAL REVIEW:**

1. **FOR ALL REFERRALS, PLEASE FAX THE FOLLOWING INFORMATION TO Laura G. (Director of Admissions) at Fax # 401-941-0089:**
   A. Correct referral packet, completed with no blanks, with attached signature page, signed by client, AND initialed client referral checklist. NOTE: **List of medications must be written on referral (just writing please see attached will not be accepted), PLEASE NOTE UNAPPROVED MEDICATIONS:**
   - Controlled Narcotics-ex. Benzodiazepines, amphetamines, opiates
   - Blood thinners
   - Medications that require regular labs for levels, ex. Lithium

   B. Referral source's intake assessment/presenting problem of client.
2. **IF REEERRAL IS APPORVED FOR ADMISSION, WE WILL NEED THE FOLLOWING PRIOR TO CLIENT'S ARRIVAL:**
   **C.** Discharge paperwork from referral source, including any medications or medication changes that differ from MAP referral packet.
   **D.** 30 day supply of all medications called into Genoa Pharmacy (P) 401-276-6370 (F) 401-276-6372, unless client is presenting with all medications in hand.
   **E.** Prior-Authorization with client's insurance for 3.5 Level of care residential (need reviewer's name/number with extension**,** approved days and auth #), this to be called in to Laura at 401-785-0050 ext 41.
   **F.** If client is on MAT (methadone, suboxone), last dose letter sent to provider, intake/follow up appointment with MAT provider. If the client is on suboxone and can be sent with a 30-day supply this is also acceptable. If not provider/referral source needs to ensure script can be sent for client.
   **G.** **Court orders:** if this is court ordered treatment, please make sure court order has the following included on it: **OUR NAME (MAP) AND ADDRESS (66 Burnett St, Providence, RI, 02907), client's name and DOB, THAT CLIENT IS BEING ORDERED TO TREATMENT AT AN SUD RESIDENTIAL 3.5 LEVEL OF CARE, AMOUNT OF TIME ORDERED INTO TREATMENT (i.e., 30, 60 or 90 days), BEGINNIG DATE of court order. NOTE: We are no longer accepting "up to orders" they must be a confirmed time length for this program (i.e., 30, 60 or 90 days.**

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| | |
|---|---|
| *Client Name:* _____ | *Date of Referral:* _____ |
| *Client DOB:*_____ ***Full** SS#:* ____ | *Referring Facility Name:*_____ |
| *Client Insurance:*_____ | *Referring Staff/ CM:* _____ |
| *Client **INSURANCE ID#**:* _____ | *Ref. Staff Number:*_____ |
| *Clients identifying gender:*_____ | *Emergency contact (name, phone #, relationship)* _____ _____ |
| *Race:* _____*Ethnicity:* _____ | |
| *Clients Primary Language:* _____ | |
| *Projected d/c date from your facility?* _____ | |

**Reason for referral/Presenting Problem** (if applicable, include recent stressors, precipitants, severity, duration of problem etc.). *Please note any behavioral concerns if applicable:*

_____

_____

_____

***Substance Use Diagnosis:***

***Primary Substance:*** _____ *CODE:* _____

***Date of Last use:*** _____ ***Age of First use:*** _____

***Route of administration:*** _____***Frequency of use:*** _____ ***Amount of use:*** _____

***Secondary Substance:*** _____ *CODE:* _____

***Date of Last use:*** _____ ***Age of First use:*** _____

***Route of administration:*** _____***Frequency of use:*** _____ ***Amount of use:*** _____

***Tertiary Substance:*** _____ *CODE:* _____

***Date of Last use:*** _____ ***Age of First use:*** _____

***Route of administration:*** _____***Frequency of use:*** _____ ***Amount of use:*** _____

**History of IV drug use?** ( ) YES or ( ) NO

**History of Overdose:** ( ) YES or ( ) NO

If yes, how many overdoses has client had? _____

When was client's last overdose and on what substance (s)? _____

Was Narcan Used? ( ) YES or ( ) NO

_____

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**MEDICATED ASSISTED TREATMENT INFORMATION**

***Is client prescribed Methadone or Suboxone?*** **( )** YES or ( ) NO

If yes, Which medication? _____

***Current Dosage:*** _____ How long on MAT? _____

Client on a stable dose? **( )** YES or ( ) NO/ When was last dose adjustment? _____

Provider Name: _____

Provider Address: _____ Phone Number: _____

**Any reported withdrawal symptoms?**

_____

***If applicable*, Treatment history over last 12 months (other than any reported MAT provider and referral source):**

**Name of Facility: _____ Date of Treatment: _____ Level of care: _____**

**Type of Discharge: Successful, Administrative, AMA/ASA/AWOL**

**Name of Facility: _____ Date of Treatment: _____ Level of care: _____**

**Type of Discharge: Successful, Administrative, AMA/ASA/AWOL**

**Name of Facility: _____ Date of Treatment: _____ Level of care: _____**

**Type of Discharge: Successful, Administrative, AMA/ASA/AWOL**

**Name of Facility: _____ Date of Treatment: _____ Level of care: _____**

**Type of Discharge: Successful, Administrative, AMA/ASA/AWOL**

***If any discharge type was ADMINISTRATIVE, please provide details:***

_____

_____

_____

**Emotional, Behavioral or Cognitive Conditions and Complications:**

***Psychiatric Diagnosis (DX):***

*DX 1:* _____ *ICD-10 CODE:* _____

*DX 2:* _____ *ICD-10 CODE:* _____

*DX 3:* _____ *ICD-10 CODE:* _____

**Any history or trauma?** ( ) YES or ( ) NO

If yes, please write a brief synopsis:

_____

_____

**Has the client had a suicide *attempt* within the last 30 days?** ( ) YES or ( ) NO

If yes, method of attempt_____ and when _____

**Has the client had any suicidal *thoughts* within the last 30 days?** ( ) YES or ( ) NO

If yes, what were the clients plan(s)_____ and when were the thoughts _____

**Any *current/ active* SI, SIB, or HI?** ( ) YES or ( ) NO

If yes, please explain further: _____

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**Any history of Auditory Hallucination/Visual Hallucination?** ( ) YES or ( ) NO
**Are hallucinations command type?** ( ) YES or ( ) NO
If yes to either question, please describe further:

_____

**Legal Concerns/Problems**

**Current legal issues/concerns:**

_____

**Is this referral for court ordered treatment?** ( )YES or ( ) NO

If yes, who is the legal representative that will be monitoring client's case?

Name: _____

Phone #: _____ Fax: _____

Which court system? _____

☐ CHECK IF UNKNOWN

Any open cases? ( )YES or ( ) NO, if yes, for what/how many? _____

Any ACTIVE warrants? ( )YES or ( ) NO

***Is the client a sex offender**: ( )YES or ( ) NO Level(circle one): 1 2 3*

*Any current or history of arson? ( )YES or ( ) NO Please Explain: _____*

*Any current restraining orders? ( ) YES or ( ) NO Who and how long?_____*

☐ CHECK IF ANY OF THESE ARE UNKNOWN

**Biomedical Conditions and Complications**

***Medical Diagnosis or Concerns** (i.e. recent/upcoming surgery, life threatening illness etc.):*

_____

_____

***Current Immunization Status (Please specify dates)***

Hepatitis A Dose #1 & 2_____ Hepatitis B Dose #1 &#2 _____

Influenzae Vaccine _____ COVID-19 Dose #1 & #2 _____

***Infectious Disease Diagnosis (Please specify dates)***

Hepatitis C Status_____ Treatment Completed Y/N; _____

HIV Status _____ Syphilis RPR _____

***Does client have a Primary Care Physician (PCP)?** Yes_____ No____ Unknown_____*

*If applicable who is the PCP? _____ Facility Name: _____*

*Any allergies (medication or food)?* ( ) YES or ( ) NO If so, what?_____

*Active MRSA*? ( ) YES or ( ) NO *Any open wounds*: ( ) YES or ( ) NO

*Does the client require a wheelchair and or cane?* ( ) YES or ( ) NO *If so, which*? _____

**Recovery and Living Environment**

Does client have a reported recovery support system? ( ) YES or ( ) NO, if yes, whom?

_____

Does client report have stable/ permanent housing, outside of treatment? ( ) YES or ( ) NO

If no, how does client plan to address this? _____

Is client currently employed? ( ) YES or ( ) NO

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***Please List all <u>ACTIVE</u> medications, please do not write 'please see attached':***

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Name of medication: _____ Dose: _____ Frequency: _____

Please note any other important information:

_____

_____

_____

**To complete this referral please do the following:**

1. Fax your facilities evaluation paperwork and last dose letter, if applicable, for anyone on MAT.
2. Have the client read, initial, and sign the attached form, and fax with referral paperwork.
3. **Once the client has been accepted and you have been given an admission date, please fax to MAP the <u>client's discharge medication list, discharge summary, and the insurance authorization information</u> to (401) 941-0089 prior to client's arrival to program. Please note, if we do not receive insurance authorization, we may not be able to accept the client into our program**.
4. **For admission, please send a 30-day supply of all client's medications to Genoa Pharmacy, 530 N Main St Suite 6, Providence, RI 02904, phone #: 401-276-6370, Fax# 401-276-6372.**

Dear prospective MAP resident,

# MAP BEHAVIORAL HEALTH
## REFERRAL FORM

**66 Burnett Street Providence, RI 02907**
**(Phone) 401-785-0050 ext. 10 (Fax) 401-941-0089**

We thank you for your interest in our program. We would like to inform you of a few important things before you potentially arrive to our facility. Please initial next to each item AND sign your name below, acknowledging that you are aware and accept the information below. Then, give to your counselor/case manager etc. to fax back to us to complete your referral.

1. _____ Our program length of stay is anywhere between 2 weeks and 90 days. The length of stay varies for each individual and is determined on a case-by-case basis.
2. _____We ask that, if accepted, you only bring 2-week (s) (14 days) worth of clothing. We do have laundry machines available for use, but you must supply your own detergent. **PLEASE NOTE: RESIDENTS ARE NO LONGER ALLOWED TO HAVE A PERSONAL TV OR VIDEO GAME SYSTEM IN THE FACILITY.**
3. _____Your insurance company pays only for your residential groups/individual sessions ONLY, not food and board. All clients are required to contribute to the house food via EBT/Food Stamp card for the time they are in the program as this will assist us in paying for your daily meals. If you do not already have EBT/Food stamps, we will assist you in applying.
4. _____**MAP clinical hours:** we provide both individual and group counseling sessions 7 days a week, holidays included, between the hours of 8:00am to 8:00pm. Groups and individual counseling sessions are mandatory. WE ARE NOT A WORKING PROGRAM. ALL CLIENTS ARE REQUIRED TO REMAIN WITHIN THE FACILITY UNLESS THEY HAVE A SCHEDULED MEDICAL OR MENTAL HEALTH APPOINTMENT OR COURT.
5. _____ **MAP no longer includes PASSES as part of their curriculum.** *******
6. _____MAP is not responsible for any loss, damaged or stolen property, please be aware of this when deciding which items to bring with you to treatment.
7. _____ **Cellphones and money**: We do not allow you to have more than $1 or cell phones on your person. We **do,** however, allow you access to the community phone daily after clinical hours and will lock and secure all cash, debit/credit cards, gift cards, personal cellphones, etc.
8. _____ **TOBACCO**: We **do** permit smoke breaks (cigarettes only). We **do not** permit vapes or chewing tobacco. These are considered contraband and will be confiscated.
9. _____ **Court Ordered Clients ONLY:** Must sign a release of information for all court advocates upon admission (i.e., Lawyer, Probation, Attorney, Public defender)
10. _____ **Court Ordered Clients ONLY:** We no longer accept "up to orders", this means if you are ordered 90 days of treatment, we require you complete the full 90-day order.

If you have any further questions, comments, or concerns, please feel free to speak to one of our staff at the number listed at the top of this document. We look forward to meeting you! ☺

**X _____ Date: _____**