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 Gina D. (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.
   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 Gina 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#:* _____	
Client Insurance: _____	*Referring Facility Name:* _____
*Client **INSURANCE ID#**:* _____	*Referring Staff/ CM:* _____
Clients identifying gender: _____	
Race: _____ *Ethnicity:* _____	*Ref. Staff Number:* _____
Clients Primary Language: _____	*Emergency contact (name, phone #, relationship)* _____ _____
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 ACTIVE 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 client's discharge medication list, discharge summary, and the insurance authorization information 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,

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(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. _____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 ALLOWED TO HAVE A PERSONAL TV OR VIDEO GAME SYSTEM IN THE FACILITY.**

3. _____**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.

4. _____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.
5. _____**Cellphones and money**: We allow you to have cell phones on your person. We will lock and secure all cash, debit/credit cards, gift cards, personal cellphones, etc.
6. _____**TOBACCO**: We **do** permit smoke breaks (cigarettes only). We permit vapes.
7. _____**Court Ordered Clients ONLY:** Must sign a release of information for all court advocates upon admission (i.e., Lawyer, Probation, Attorney, Public defender)
8. _____**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:** _____