Pascal Crisis Services, Inc.

Robert A. Pascal Youth & Family Services, Inc.
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(410) 975-0067

3.7WM Detox/Withdrawal Management Referral

Client Information

Name: ____ **Age:** ______ **DOB:** ______/_______/________

Sex: Male ☐ Female ☐ Other ☐ SSN: _______-_______-___________ **Race:** ______________________

Address: ____ **County of Residence:** ______________

City/State/Zip: ____ **Phone:** _______________________

Insurance: ☐Uninsured ☐Medical Assistance (State) ☐Medicare ☐Private/Commercial: ________________

Substance Use History

Please list information for all known substance use:

Substance	Date of Last Use	Route of Use	Frequency	Amount Used	Age of First Use

History of Overdoses? Yes ☐ No ☐ *If yes, when was your last overdose?* _______________

History of Seizures? Yes ☐ No ☐

If yes, when was your last seizure? ______________________

Was this due to withdrawing from a substance? Yes ☐ No ☐

Substance Use History

Have you ever been to treatment for substance use? Yes ☐ No ☐ If yes, list known details below:

Name of Facility	Date	Type of Treatment (Inpatient, PHP, IOP, Outpatient)	Was this program completed successfully?

Are you, or have you ever been on MAT? Yes ☐ No ☐

If yes, what type of MAT? ☐ Methadone ☐ Suboxone/Subutex ☐Vivitrol ☐Other: ______________

Medical Information

Do you have or ever had any of the following? Please check all that apply.

☐ Heart Disease ☐ Arthritis ☐ Migraines ☐ Stroke
☐ Lightheadedness ☐ Diabetes ☐ Tuberculosis ☐ Hernia
☐ Cancer ☐ Ulcers ☐ High Blood Pressure ☐ Liver Disease
☐ Abscesses ☐ Head Injury ☐ Shortness of Breath ☐ Kidney or Thyroid Disease
☐ HIV ☐ Hepatitis ☐ Lung Disease (COPD, Asthma, Emphysema, Bronchitis)

Other:____

Do you have any allergies? Yes ☐ No ☐

If yes, please list all allergies: ____

Are you pregnant? Yes ☐ No ☐ *If yes, how far along are you (weeks)?* _______________

Mental Health History

Do you have or ever had any of the following mental health concerns? Please check all that apply.

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ PTSD
☐ Psychosis ☐ Schizophrenia ☐ ADD/ADHD ☐ Personality Disorder

Other: ____

Medication Information

Do you take or are you supposed to take prescription medication? Yes ☐ No ☐ If yes, list below:

Medication Name	**Medication Dosage/Frequency**

Legal History

Do you have any current legal issues? Yes ☐ No ☐ If yes, list details below:

____

____

Initial Eligibility Screening

Have you ever been charged with a sex offense? ☐ Yes ☐ No

Do you need assistance performing normal activities of daily living (toileting, medication administration, showering, etc.)? ☐ Yes ☐ No

Residential clients are required to go up and down three flights of stairs several times a day for groups and classes. Is this something that will be an issue for you? ☐ Yes ☐ No

If you answered "Yes" to any of the questions above, STOP. We cannot take a referral for this individual.

Referral Source

Name: ____ Title: ____

Organization: ____ Phone: __________________________

Referral Source Signature (with credentials): _____________________________________ Date: ___________

Client Signature:____ Date:_____________