**Departmental Approval Page**

**(for use by Palmetto Corner Staff only)**

**Clinical Approval**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Approval**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Administrative Approval**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Anticipated Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Palmetto Corner Admission Form**

| Last Name:  | First Name:  | MI:  |
| --- | --- | --- |
| Race:  | Age:  | Gender:  | Phone:  | Date:  |
| Address:  | City/State/Zip:  |
| SSN:  | DOB:  | County:  |
| Emergency Contact:  | Phone #: | Alt Phone # |
| Referring Agency:  | Contact Name:  | Phone #:  |
| Does the patient have health insurance?  | Yes:  | No: |
| Company Name:  |
| Medicaid or Member Number:  |

**Substance Abuse History**

| **Substance** | **Amt Per Day** | **How Long** | **Last Day**  | **Substance** | **Amt Per Day** | **How Long** | **Last Day**  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Alcohol |  |  |  | Heroin |  |  |  |
| Cannabis |  |  |  | Methadone |  |  |  |
| Cocaine |  |  |  | Other Opiates |  |  |  |
| Hallucinogens |  |  |  | Sedative |  |  |  |
| Other |  |  |  | Stimulants |  |  |  |

**DSM-V Diagnostic Codes for Substance Use Disorders**

| **Substance** | **Severe/Mod** | **Mild** | **Substance** | **Severe/Mod** | **Mild** |
| --- | --- | --- | --- | --- | --- |
| Alcohol | F10.20: | F10.10: | Opioids | F11.20: | F11.10: |
| Cannabis | F12.20: | F12.10: | Sedatives | F13.20: | F13.10: |
| Cocaine | F14.20: | F14.10: | Stimulants | F15.20: | F15.10: |
| Hallucinogens | F16.20: | F16.10: | Tobacco | F17.20: | F17.10 |
| Other |  |  |  |  |  |
| Cognitive or behavioral issues:  |
| What is motivating the patient:  |
| How many outpatient treatment episodes for SUD?  | How many inpatient/residential episodes for SUD?  |
| Longest recovery time:  |
| Housing status (stable/unstable/toxic):  |

**Treatment History**

| **Type of Treatment** | **Number of Times** | **Date** |
| --- | --- | --- |
| Inpatient (Yes/No) |  |  |
| Outpatient (Yes/No) |  |  |
| Detoxification Only |  |  |
| Methadone Maintenance | Dosage: N/A  |  |
| Suboxone Maintenance | Dosage: N/A |  |

**Legal Status**

| Probation/Parole (Yes/No):  | Warrant (Yes/No):  |
| --- | --- |
| Court Date Pending (Yes/No):  | Pending Court Date:  |
| Charges:  |

**Psychiatric Status**

| **Psychiatric Status** | **Within the Past Month** | **Within the Past Year** |
| --- | --- | --- |
| Suicidal thoughts/attempts | Yes/No:  | Yes/No:  |
| Thoughts of self-mutilation (acts) | Yes/No:  | Yes/No:  |
| Homicidal Thoughts/Attempts | Yes/No:  | Yes/No:  |
| Hallucinations (auditory, visual or tactile) | Yes/No:  | Yes/No:  |
| If Yes, explain: |
| Is the patient psychiatrically stable enough to fully participate in treatment at Palmetto Corner (Yes/No):  |

**Medical Status**

| Is the patient medically stable (yes/No): |
| --- |
| Current Medication | Dose Frequency | How Long Taken | Current Medication | Dose Frequency | How Long Taken |
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| **Medical Problems, Recent Illnesses or Injuries:** |
| 1.  |
| 2.  |
| 3.  |
| 4.  |
| **Allergies, Please list all:** |
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