Recovery Centers of Montana

Dear Client,

To make your check-in to Recovery Centers of Montana simpler, we have a list of acceptable items that are permitted on our premises while you are enrolled in our program. Any items that you bring that are not on this list will be stored in a locked room until your departure. ***RCM is not responsible for lost or stolen items.

1. **Wallets and keys will be stored with a label in a secured area.**
2. **Phones are not permitted on campus so leave your cell phone with a trusted family member or friend.**

Weapons of any kind, alcohol, and/or drugs are not permitted on our property. Authorities will be notified if they are found.

If you have prescription medications that you will need during your stay with us, please have that prescription filled prior to your arrival. Your prescription medications will be stored in a secured area and dispensed as prescribed.

Recovery Centers of Montana IS NOT a detox facility. Please make sure you have detoxed before your bed date.

If you smoke cigarettes, bring unopened packs. If you roll your own cigarettes, it must be a new and sealed package. RCM will purchase cigarettes twice a week. Client must provide cash to purchase cigarettes as RCM does not accept any other form of payment. IF you do not cash, you will not be able to make purchases. If someone wishes to send client cash, they can mail it to the following address:

Recovery Centers of Montana "The Ranch"-Men's Facility
Attention: (Client's first and last name here)
390 Hodgson Road
Columbia Falls, Montana 59912

Recovery Centers of Montana "The Lodge"-Women's Facility
Attention: (Client's first and last name here)
PO Box 260137
Martin City, Montana 59926

If client wishes to correspond with family and/or friends they must bring envelopes and postage
The check-in procedure will include a thorough search of your belongings as well as a body search, breathalyzer, and urine analysis. Client will be allowed ONE brief phone call at intake if anyone needs to be notified of safe arrival.

RCM supplies toiletries, linens, and towels. RCM has a laundry room supplied with detergent.
Below is the comprehensive list of the ONLY items allowed on the premises.

CLIENT PACKING LIST			
7	Pants	1	Belt
7	Shirts	1	Piece of jewelry (ring or earrings)
7	Underwear	1	Coat or Sweater (Fall or Winter only)
7	Pairs of socks	1	Sweatshirt or sweater
2	Pair of shoes	2	Sets of pajamas
2	Pair of Thermals or Sweats	2	Books
1	Slippers	1	Brush or comb
1	Nail Clipper		Unopened toiletries/5 pieces of makeup

RCM 2

Visits with family or friend(s) is not permitted during your stay at RCM. Personal belongings cannot be delivered to you during your stay with us. Bring what is needed according to the list provided on Page one.

RCM requires proof that you have had a physical 12 months. Bring documents of proof or email to: rdaly@rcofmt.com

In addition, The Intake Coordinator will schedule an arrival date and time for coming into the program. **If for some reason you are running a few minutes late, you must notify the staff at 406.607.5600.** If you are unnecessarily late in arriving, you could forfeit your place in the program and be moved to the next available slot on the program schedule.

Clients are not allowed to have their vehicle on the property while in the program so you will need to arrange for transportation. Please notify us of your travel arrangements.

We appreciate your cooperation in making your intake process smooth and stress-free. As always, if you have any questions, please do not hesitate to contact us. To reach admissions:

406.607.5600

Sincerely,
Recovery Centers of Montana

By signing this document, I acknowledge that I have read and understand the information provided.

Name: _____ Date: _____

Recovery Centers of Montana

CONSENT TO TREATMENT FORM

Resident's Name: (Last)_____ (First)_____ Initial____

Date of Birth: _____ Age: _____ Gender: _____

Phone: _____ Email: _____

Resident's Current Physical Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

First Name: _____ Last Name:_____

Address: _____ Phone: _____

SERVICE TREATMENT AUTHORIZATION FORM

I, _____, do hereby grant the Clinical Staff of RCM authorization to:

- Provide psychological testing, behavioral assessment, emotional assessment and a biopsychosocial assessment.
- Therapy which can include chemical dependency education, individual therapy, family therapy, behavior modification, relaxation therapy, and/or trauma therapy.

This grant of temporary authority shall begin on _____ (date) and shall remain effective until _____ (date, 1 year from today).

Resident's Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana

60 Day Residential Treatment Program

APPLICATION FOR SERVICES

A phone interview will be conducted with the applicant before final determination of acceptance is final

Date: _____

Name: _____ _____ _____
(Last) (First) (MI)

Gender: M ☐ F ☐ Date of Birth _____ Age: _____ SS#: _____ _____ _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

County of Residence: _____ Email: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Cohabitating ☐

Race/Ethnicity

White ☐ Native Indian ☐ Asian Indian ☐ Black ☐ Alaskan Native ☐ Hispanic ☐

Enrolled Tribal Member: Yes ☐ No ☐ Tribe: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

Health Insurance: *** Medicare does not cover treatment. If you have Medicare/Medicaid, you need to contact Medicaid to discuss your spend down for treatment.

Medicaid ☐ None ☐ Other: _____

Insurance ID #: _____ Preauthorization Required: Yes ☐ No ☐

Name of Insured: _____ Relationship: _____

Substances used in the past 30 days: _____ _____ _____

_____ _____ _____ _____

Do you experience withdrawal symptoms when you stop using substances? Yes ☐ No ☐

If yes, What symptoms: _____

_____

Who is your physician/practitioner that prescribes your medications?

Name: _____ Phone: _____

Which pharmacy(s) do you get your medications from:

_____ Phone: _____

Current medications and dosages: ***You must provide a current & complete medication list

_____ _____ _____

_____ _____ _____

_____ _____ No Meds ☐

_____

Physical Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Medical Issues (diabetes, heart disease, liver disease, etc.) **Proof of TB test w/i last 12 months required. Either bring with you or email to: rdaly@rcofmt.com

_____

Any special medical needs/accommodaitons (wheel chair, hearing, vision): _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Current Diagnosis:

Substance Use Disroder: _____ Mental Health: _____

Have you ever used drugs by injection? Never ☐ Currently Using ☐ Within 1-12 months ☐ 12+ months ☐

_____

Have you been incarcerated in the past 30 days? Yes ☐ No ☐ How many days? _____

List all legal involvement (current and prior

_____

_____

_____

Are you required to register as a sexual/violent offender? Yes ☐ No ☐

Are you:

On Probation ☐ On Parole ☐ Incarcerated ☐ On Pre-release ☐ DUI Offender ☐ Mandatory Monitoring ☐

Name of Probation Officer: _____ **Phone:** _____

Name of Attorney: _____ **Phone:** _____

I understand, if accepted, I am entering a 60 day program. _____ (initial)

Signature of Applicant: _____ *Phone:* _____

Recovery Centers of Montana

Drug Abuse Screening Test (DAST-10)

General Instructions:

"Drug Use" Refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any non-medical use to drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (i.e. paint thinner), tranquilizers (i.e. Valium), barbiturates, cocaine, stimulants (i.e. speed), hallucinogens (i.e. LSD), or narcotics (i.e. heroin). The questions DO NOT include alcoholic beverages.

Please answer every question. If you have difficulty responding, choose the responds that is *mostly* right.

Client Name (printed): _____ Date: _____

These questions refer to drug use in the last 12 months. Please answer NO or YES.

1. Have you used drugs other than those required for medical reasons? **NO** **YES**
2. Do you use more than one drug at a time? **NO** **YES**
3. Are you always able to stop using drugs when you want to? **NO** **YES**
4. Have you had "blackouts" or "flashbacks" as a result of drug use? **NO** **YES**
5. Do you ever feel bad or guilty about your drug use? **NO** **YES**
6. Does your spouse (or parents) ever complain about your involvement with drugs? **NO** **YES**
7. Have you neglected your family because of your use of drugs? **NO** **YES**
8. Have you engaged in illegal activities in order to obtain drugs? **NO** **YES**
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? **NO** **YES**
10. Have you had medical problems as a result of your drug use (i.e., memory loss, hepatitis, convulsions, bleeding, etc.)? **NO** **YES**

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371. Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties.

Recovery Centers of Montana

Scoring the Screening Test:

Score 1 point for each question answered "Yes", except for question 3 for which a "No" receives 1 point.

DAST Score: _____

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No Problems Reported	None at this time
1-2	Low Level	Monitor, Reassess at later date
3-5	Moderate Level	Further Investigation
6-8	Substantial Level	Intensive Assessment
9-10	Severe Level	Intensive Assessment

Client Signature: _____ Date: _____

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371. Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties.

Client Name: _____ Date: _____

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.

1	Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	YES	NO
2	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	YES	NO
3	Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	YES	NO
4	Can you stop drinking without a struggle after one or two drinks?	YES	NO
5	Do you ever feel guilty about your drinking?	YES	NO
6	Do friends or relatives think you are a normal drinker?	YES	NO
7	Are you able to stop drinking when you want to?	YES	NO
8	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	YES	NO
9	Have you gotten into physical fights when drinking?	YES	NO
10	Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	YES	NO
11	Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	YES	NO
12	Have you ever lost friends because of drinking?	YES	NO
13	Have you ever gotten into trouble at work or school because of drinking?	YES	NO
14	Have you ever lost a job because of drinking?	YES	NO
15	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	YES	NO
16	Do you drink before noon fairly often?	YES	NO
17	Have you ever been told you have liver trouble? Cirrhosis?	YES	NO
18	After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices or seen things that really were not there?	YES	NO
19	Have you ever gone to anyone for help about your drinking?	YES	NO
20	Have you ever been in a hospital because of drinking?	YES	NO
21	Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem.	YES	NO
22	Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? _____)	YES	NO
23	Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? _____)	YES	NO
24	Have you ever been arrested, or taken into custody, even for a few hours, because of other drunk behavior? (If YES, how many times? _____)	YES	NO

Scoring the MAST

The version of the MAST included on this screening was provided by Professor Selzer, who indicated that the version published in 1971 in the American Journal of Psychiatry was modified in 1980.

In scoring the MAST points are assigned to a response depending upon whether the item is worded positively or negatively.

For items 1, 4, 6 and 7 negative answers are consistent with alcoholic responses.

For items 2, 3, 5 and 9-24 positive responses are consistent with alcoholic responses.

The scale assigns a 1-5 weighting to each of the items, with a rating of 5 being considered diagnostic of alcoholism. Questions that were highly discriminating were given a value of two points and others assigned a one-point value. An alcoholic response to questions 8, 19, 20 is considered diagnostic and is assigned to value of five points.

A total score is computed as a sum of item values as seen in the table below. Total scores range from 0-53.

	QUESTIONS	Points Assigned
1	(Negative responses are alcoholic)	
2		
3		
4	(Negative responses are alcoholic)	
5		
6	(Negative responses are alcoholic)	
7	(Negative responses are alcoholic)	
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

Citation: Selzer ML: The Michigan Alcoholism Screening Test (MAST): the quest for a new diagnostic instrument. American Journal of Psychiatry 3:176-181, 1975

Date: _____

First Name: _____ MI: ___ Last Name: _____

TCU DRUG SCREEN 5

During the last 12 months (not including any controlled environments such as inpatient, jail, prison, etc.)

	QUESTIONS	YES	NO
1	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?		
2	Did you try to control or cut down on your drug use but were unable to do it?		
3	Did you spend a lot of time getting drugs, using them or recovering from their use?		
4	Did you have a strong desire or urge to use drugs?		
5	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?		
6	Did you continue using drugs even when it led to social or interpersonal problems?		
7	Did you spend less time at work, school, or with friends because of your drug use?		
8	Did you use drugs that put you or others in physical danger?		
9	Did you use drugs even when it was causing you physical or psychological problems?		
10a	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?		
10b	Did using the same amount of a drug lead to it having less of an effect as it did before?		
11a	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?		
11b	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?		

12. Which drug caused the most serious problem during the last 12 months? (CHOOSE ONE)

- o None
- o Alcohol
- o Cannabinoids – Marijuana (weed)
- o Cannabinoids – Marijuana (hash)
- o Synthetic Marijuana (K2, Spice)
- o Opioids – Heroin (smack)
- o Opioids – Opium (tar)
- o Stimulants – Powder Cocaine (coke)
- o Stimulants – Crack Cocaine (rock)
- o Stimulants – Amphetamines (speed)
- o Stimulants – Methamphetamine (meth)
- o Synthetic Cathinones (bath salts)
- o Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)
- o Dissociative Drugs – Ketamine/PCP (Special K)
- o Hallucinogens – LSD/Mushrooms (acid)
- o Inhalants – Solvents (paint thinner)
- o Prescription Medications – Depressants
- o Prescription Medications – Stimulants
- o Prescription Medications – Opioid Pain Relievers
- o Other (Specify) _____

13. How often did you use each type of drug during the last 12 months?		Never	Only a few times	1-3 times per mo.	1-5 times per week	Daily
a	Alcohol					
b	Cannabinoids – Marijuana (weed)					
c	Cannabinoids – Hashish (hash)					
d	Synthetic Marijuana (K2, spice)					
e	Opioids – Heroin (smack)					
f	Opioids – Opium (tar)					
g	Stimulants – Powder Cocaine (coke)					
h	Stimulants – Crack Cocaine (rock)					
i	Stimulants – Amphetamines (speed)					
j	Stimulants – Methamphetamines (meth)					
k	Synthetic Cathinones (bath salts)					
l	Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)					
m	Dissociative Drugs – Ketamine/PCP (Special K)					
n	Hallucinogens – LSD/Mushrooms (acid)					
o	Inhalants – Solvents (paint thinner)					
p	Prescription Medications -Depressants					
q	Prescription Medications – Stimulants					
r	Prescription Medications – Opioid Pain Relievers					
s	Other (specify) _____					

14. How many times before now have you ever been in a drug treatment program?
(DO NOT INCLUDE AA/NA/CA MEETINGS)

Circle One: Never 1 time 2 times 3 times 4 + times

15. How serious do you think your drug problems are?

Circle One: Not at all Slightly Moderately Considerably Extremely

16. During the last 12 months, how often did you inject drugs with a needle?

Circle One: Never Only a few times 1-3 times/month 1-5 times a week Daily

17. How important is it for you to get drug treatment now?

Circle One: Not at all Slightly Moderately Considerably Extremely

Client Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana

BIOPSYCHOSOCIAL Name: _____

Demographics:

Referral Source _____

Have you ever been in the military? Yes ☐ No ☐

Marital Status: Married ☐ Single ☐ Divorced ☐ Cohabitating ☐

Does your spouse use? Yes ☐ No ☐

Do you have children? Yes ☐ No ☐

Living Environment:

Group Home ☐ Homeless ☐ Independently ☐ With Family ☐ With Parent ☐

Describe your living environment and how it affects your recovery.

_____

_____

_____

Is it a sober environment? Yes ☐ No ☐

Would you like to involve family, spouse, or significant other in family therapy? Yes ☐ No ☐

Family/Friend History:

Does anyone in your family have a history of mental illness? Yes ☐ No ☐

Does anyone in your family have a history of substance/alcohol abuse? Yes ☐ No ☐

Family History:

_____

What is the relationship of your parents?

Married ☐ Divorced ☐ Widowed ☐ Deceased ☐ Separated ☐ Single Parent ☐

Describe your relationship with your parents: _____

Do you have siblings? Yes ☐ No ☐

Do you currently have family that supports your recovery? Yes ☐ Denies having family support ☐

How many close friends do you have? _____

How often do you use with your friends? _____

Describe your relationship with your friends _____

Describe your relationship with your co-workers _____

Do you currently have friends that support your recovery? Yes ☐ Denies having family support ☐

Religion/Spirituality:

Are there any cultural influences and/or preferences that could impact your treatment here?

Yes ☐ No ☐

Religious/Spiritual Preference _____

Are you currently practicing your religion/spirituality? Yes ☐ No ☐

What is your history with spirituality? _____

What kind of spiritual activities do you participate in and how does it affect your recovery?

How would you like to incorporate spirituality into your recovery? _____

What do you do for social or leisure activities and how can it support your recovery? _____

Have you cut down the amount of time you participate in activities because of your substance use?
How?_____

Vocational/Educational/Economic Background:

Highest Grade/Degree Completed: _____

Literate: Yes ☐ No ☐

Have you had vocational training? Yes ☐ No ☐

Are you a student? Yes ☐ No ☐

Has your addiction/use caused problems with your schooling? Yes ☐ No ☐

How do you learn best?

By Seeing Things ☐ By Hearing Things ☐ By Touching Things ☐ By Writing Things ☐

Do you have any diagnosed learning disabilities including attention deficit hyperactivity disorders? Yes ☐ No ☐

Employment History:

Employer: _____ Start Date: _____ End Date: _____

Position: _____ Reason for Leaving _____

Have you ever missed work because of your substance use? Yes ☐ No ☐

What is your current financial status? Self-sufficient ☐ Supported by family ☐ Struggling ☐

How does your financial status effect your addition?

_____

Substance Use History:

Have you used any of the following?

	Substance	Age first used	Amount	Frequency	Route (oral, IV, etc)	Date of Last Use
	Alcohol					
	Ambien					
	Amphetamine					
	Angel Dust					
	Ativan					
	Cocaine					
	Crack Cocaine					
	E-Cigarette					
	Ecstasy					
	Heroin					
	Inhalants					
	Klonopin					
	LSD					
	Marijuana					
	Methadone					
	Mushrooms					
	Oxycodone					
	Oxycontin					
	Roxicodone					
	Suboxone					
	Tobacco					
	Tranquilizers					
	Xanax					
	Other Rx Opiates					
	Other					
	Other					

Consequences of Use:

What is your primary drug of choice? _____

Do you find it takes more or less alcohol/drugs to get the same effect it once did? More ☐ Less ☐

QUESTIONS	YES	NO
Have you ever had a blackout?		
Have you ever tried to hide your substance use from others?		
Have you ever tried to cut down or stop your substance use?		

QUESTIONS	Yes	No
Have you ever used substance in the morning?		
Do you feel you have a problem with substances?		
Have you ever driven while under the influence of substances?		
Have you ever been arrested on charges related to substances?		
Have you ever avoided an event because of your substance use?		
Have multiple arrests been made for substance related charges?		
Have you ever had periods of frequent intoxication/highs or binge use?		
Have you ever lost friends or relationship because of substance use?		
Has anyone ever said they were concerned about your substance use?		
Have you decreased your social/recreational activities because of your substance use?		
Have you ever felt bad or guilty about your substance use?		
Have you ever used substance more than you intended?		
Have you ever used substances beyond an 18-hour period?		

As a result of using substances, have you ever neglected:

Family ☐ Work ☐ School ☐ Other ☐ _____

What consequences have you experienced due to drug or alcohol use? _____

_____

HIGH RISK BEHAVIORS	Yes	No
Drinking/drugging and driving		
Unprotected Sex		
Selling/distributing drugs		
Carrying weapons		
Other:		

Treatment and Recovery History:

Have you ever been treated for substance abuse? Yes ☐ No ☐

Have you ever attended a meeting of AA or NA? Yes ☐ No ☐

Have you ever had a sponsor? Yes ☐ No ☐

Longest length of sobriety? _____

How did you remain sober? _____

Why did you relapse? _____

Other Addictive Behaviors: _____

Describe your strengths that will help you with recovery _____

_____

Describe your challenges or barriers to recovery _____

_____

Client's perception of potential for sustained recovery _____

_____

Client's expectation for this time in treatment in their own words _____

_____

Current level of impairment: None ☐ Slight ☐ Moderate ☐ Severe ☐

Legal History:

Do you have a history of legal problems? Yes ☐ No ☐
Do you have any criminal charges pending? Yes ☐ No ☐ ☐
How does your legal history affect your recovery? _____

_____

_____

Are you currently on probation: Yes ☐ No ☐

Do you have a valid driver's license: Yes ☐ No ☐

Medical History:

Have you ever experienced any of the following?

Denies ☐ DT's ☐ Hangovers ☐ Headaches ☐ Nausea ☐ Seizures ☐ Shakes ☐
Vomiting ☐ Other ☐ _____ _____ _____

Have you ever been treated for:

Denies ☐ Cirrhosis ☐ Esophagitis ☐ Hepatitis ☐ Pancreatitis ☐

Have you ever been treated for tingling or pain in your feet?

Have you ever had any major injuries or surgeries?

When was the last time you had a medical examination? _____
(If over 12 months, you must have a physical examination and provide documentation of exam and TB test to RCM)

Are you experiencing any physical pain?

Nutrition Health Screening:

How many days a week do you eat breakfast? _____

How many days a week do you eat lunch? _____

How many days a week do you eat dinner? _____

How often do you eat between meal or after dinner? _____

How much water do you drink each day? _____

How many times per week do you eat out or take out a meal? _____

Are you a vegetarian/vegan? No☐ Vegetarian☐ Vegan ☐

Do you take any vitamin, mineral, or herbal supplements? Yes No

Do you use any pills or teas to lose weight? Yes No

How often do you use protein powders, creatin, or other supplements that claim to increase muscles? _____ What types? _____

QUESTIONS	YES	NO
Are you on a special diet for medical reasons?		
Have you had weight loss or gain of 10 pounds or mor in the last 3 months?		
Do you have dental problems?		
Do you have food allergies?		
Do you feel anxious about gaining weight?		
Are you preoccupied with losing weight?		
Do you restrict your food intake to lose weight?		
Do you feel like a bad person if you gain weight?		
Do you think of certain foods as either being "good" or "bad" and feel guilty about eating "bad" foods?		
Do you use food to comfort yourself?		
Do you vomit or have you thought about vomiting as a way to control your weight?		
Do you use laxatives, water pills, etc. to prevent weight gain?		

Homicide/Suicide Risk Assessment:

QUESTIONS	YES	NO
Have you ever thought about hurting and/or killing yourself?		
Have you ever had a plan?		
Have you ever had means to hurt or kill yourself?		
Have you ever tried to hurt yourself?		
Have you ever thought about hurting and/or killing anyone else?		
Have you ever made a plan to hurt or kill anyone else?		
Have you ever had the means to hurt or kill anyone else?		
Have you ever tried to hurt or kill anyone else?		
Do you possess any firearms or weapons?		
Do you have access to any lethal means (weapons, poison, sharps, high doses of lethal substance) to injure yourself or others?		
Have you ever received treatment/counseling for Mental Health issues?		

Protective Factors:

QUESTIONS	YES	NO
Do you feel you've received good or effective treatment for any mental, physical, or addiction disorder?		
Do you feel these services and supports have been easily available to you?		
Do you feel you have a strong and supportive relationship with your family? Comments: _____		
Do you feel you have strong community supports (i.e. church, friends, neighbors)? Comments: _____		
Do you feel you have support with your current medical or mental health providers? Comments: _____		
Do you feel you have any existing skills to effectively problem solve or resolve any conflicts in a non-violent way? Comments: _____		
Do you have any cultural or spiritual beliefs that help prevent any actions to harm yourself or others? Comments: _____		

Trauma Screening

QUESTIONS	YES	NO
Have you ever been sexually abused?		
Have you ever been physically abused?		
Have you ever been emotionally abused?		
Have you ever been taken advantage of sexually?		
Have you ever been taken advantage of financially?		
Have you ever witnessed a traumatic event not previously mentioned (i.e. death of a loved one, medical trauma, kidnapping, natural disaster, animal attack, human trafficking, war, surviving a fire, etc.)?		
Has there been a time in your life that your basic needs were not met (i.e. food, water, shelter, etc.)?		
Have you ever sexually abused anyone?		
Have you ever physically abused anyone?		
Have you ever emotionally abused anyone?		

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

	General Information		Correspondence
	Transition/Discharge Summary		Biopsychosocial Eval/Assessment
	Mental Health Assessment		Progress Notes
	Physician Orders		Medication Records
	General Progress in Treatment		Continued Care Plan
	Continued Stay Reviews		Insurance
	History and Physical		Other:
	Treatment Plan		Other:
	Dates in Program		Other:
	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: _____

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: Cedar Creek Integrated Health Ronan/St. Ignatius

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (406) 745-3681 Fax: _____ Email: _____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

I, the undersigned, have read the above and authorize staff of the disclosing facility named to disclose such information as contained above. I understand that I may revoke or cancel this authorization at any time I feel necessary. Withdrawal of this signed authorization will remain in effect for 365 days (1 year) to carry out the purpose for which my permission was given. I understand that the program releasing these records is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the information that is to be disclosed and who can see the information. A photocopy of this authorization form is as valid as the original.

Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

X	General Information	X	Correspondence
X	Transition/Discharge Summary	X	Biopsychosocial Eval/Assessment
X	Mental Health Assessment	X	Progress Notes
X	Physician Orders	X	Medication Records
X	General Progress in Treatment	X	Continued Care Plan
X	Continued Stay Reviews	X	Insurance
X	History and Physical		Other:
X	Treatment Plan		Other:
X	Dates in Program		Other:
X	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: LEGAL COMMUNICATIONS

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: Alpenglow Clinic
Address: 285 2nd Avenue West North
City: Kalispell State: Montana Zip Code: 59901
Phone: 406.890.2570 Fax: 406.314.6186 Email: alpenglowclinic@outlook.com

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

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Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

X	General Information		Correspondence
	Transition/Discharge Summary		Biopsychosocial Eval/Assessment
	Mental Health Assessment		Progress Notes
X	Physician Orders	X	Medication Records
X	General Progress in Treatment		Continued Care Plan
	Continued Stay Reviews		Insurance
X	History and Physical		Other:
	Treatment Plan		Other:
X	Dates in Program		Other:
	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: **MEDICAL**

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: **GLACIER MEDICAL – COLUMBIA FALLS & WHITFISH**
Address: **1111 Baker Avenue**
City: **Whitefish** State: **Montana** Zip Code: **59937**
Phone: **406.862.2515** Fax: Email:

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

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Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

X	General Information		Correspondence
	Transition/Discharge Summary		Biopsychosocial Eval/Assessment
	Mental Health Assessment		Progress Notes
X	Physician Orders	X	Medication Records
	General Progress in Treatment		Continued Care Plan
	Continued Stay Reviews		Insurance
X	History and Physical		Other:
	Treatment Plan		Other:
X	Dates in Program		Other:
	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: **HEALTH CARE**

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: **HEAVEN'S PEAK HEALTH CARE**
Address: **1035 9TH Street West**
City: **Columbia Falls** State: **Montana** Zip Code: **59912**
Phone: **406.897.2000** Fax: Email:

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

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Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

X	General Information	X	Correspondence
	Transition/Discharge Summary		Biopsychosocial Eval/Assessment
	Mental Health Assessment		Progress Notes
	Physician Orders		Medication Records
	General Progress in Treatment		Continued Care Plan
	Continued Stay Reviews		Insurance
	History and Physical		Other:
	Treatment Plan		Other:
X	Dates in Program		Other:
	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: **INSURANCE/SNAP BENEFITS**

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: **MEDICAID MONTANA/DPHHS**
Address: **1400 East Broadway Street**
City: **Helena** State: **Montana** Zip Code: **59601**
Phone: **406.444.4540** Fax: Email:

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

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Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

X	General Information		Correspondence
X	Transition/Discharge Summary		Biopsychosocial Eval/Assessment
	Mental Health Assessment	X	Progress Notes
	Physician Orders		Medication Records
X	General Progress in Treatment	X	Continued Care Plan
X	Continued Stay Reviews		Insurance
	History and Physical		Other:
X	Treatment Plan		Other:
X	Dates in Program		Other:
	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: **LEGAL COMMUNICATIONS**

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: **OFFICE OF PUBLIC DEFENDER**

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

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Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

X	General Information		Correspondence
X	Transition/Discharge Summary		Biopsychosocial Eval/Assessment
	Mental Health Assessment		Progress Notes
	Physician Orders		Medication Records
X	General Progress in Treatment	X	Continued Care Plan
X	Continued Stay Reviews		Insurance
	History and Physical		Other:
X	Treatment Plan		Other:
X	Dates in Program		Other:
	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: **LEGAL COMMUNICATIONS**

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: **PRETRIAL SERVICES**

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

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Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____

Recovery Centers of Montana, LLCRCM 55-105-225.01 Revised 12.3.2021

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Social Security Number: _____

Authorization for Release of Information

The extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require you to request the minimum information necessary to complete required purpose of this release.

X	General Information		Correspondence
	Transition/Discharge Summary		Biopsychosocial Eval/Assessment
	Mental Health Assessment	X	Progress Notes
	Physician Orders		Medication Records
X	General Progress in Treatment		Continued Care Plan
	Continued Stay Reviews		Insurance
	History and Physical		Other:
X	Treatment Plan		Other:
X	Dates in Program		Other:
	TB Skin Test Results		Other:

Date Release Revoked: _____ Initial: _____

Purpose of need for disclosure: _____**PROBATION COMPLIANCE**_____

Permission is given to EXCHANGE information between:

Recovery Centers of Montana, LLC, 390 Hodgson Road, Columbia Falls, MT 59912

And:

Name: **PROBATION AND PAROLE**

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Fax: Email:

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

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Patient Signature: _____ Date: _____

RCM Staff Signature: _____ Date: _____