Innovative Behavioral Health System for Woman
Referral Form

Please include biopsychosocial, medication list and discharge summary

Screener: _____ Client #: _____ Date of Admission: _____

Demographics

Client Name: _____ Date of Birth: _____

Address/Living Situation: _____

Contact #: _____

Current Manage Care Organization: _____

Medicaid Id#: _____ M#: _____

Client SS#: _____ Age: _____ Gender: _____ Race: _____

Marital status: _____ Religion: _____

Highest Grade Completed: _____ Do you have any learning disabilities? _____

Any children under age 18: _____ If yes, how many: _____

# of prior SA Admissions: _____

Month/Year: _____ Location: _____

Military History: yes/no If yes, please list branch: _____

Have veteran affairs have been contacted? ____ Type of Discharge: _____

Legal Information

Have you been arrested within the past 12months? 30 days?

If so, do you have pending charges? yes/no

Charges_____

_____ County_____

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Income

Type of Income: _____Amount per month? _____ Payee? yes/no

Reason for referral: _____

Mental Health Diagnosis: _____

Psychotropic Medications: _____

Medical Conditions: _____

Medical Medications: _____

Barriers to treatment: _____

Substance Use History

Substance used	Age of onset	Frequency	Route of administration	Date of last use
Alcohol				
Anti-Anxiety				
Amphetamines				
Barbiturates				
Cocaine				
Hallucinogens				
Heroin/Other Opiates				
LSD/Acid				
Marijuana				
Meth/Crystal				
Tobacco				
Other				

Primary drug of choice: _____

Secondary drug of choice: _____

Tertiary drug of choice: _____

Primary Diagnosis: _____

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ASAM Criteria

Withdrawal Symptoms - Low Medium High GAF Score: _____

I: Withdrawal Potential _____ II: Biomedical Conditions_____

III: Emotional/Behavioral/Cognitive Conditions _____

IV: Readiness to Change_____ V: Relapse/Continued Use _____

VI: Recovery Living Environment _____

VIII: Amount of Clean/Sober Time ☐months _____ ☐years _____

Level of Care Recommendation: ☐ Residential 3.1 ☐ IOP ☐OP

Referred by: _____ Referral Date: _____

Phone: _____

Organization: _____

Client Signature: _____ Date: _____

Screener Signature: _____ Date: _____

Upon completion of all documents fax to:866-910-5074 or email to: intake@lightoftruthcenter.org

Please allow up to 24-48 hours for a reply. Rest assured, someone will get back to you as soon as possible