TWIN OAKS REFERRAL

Twin Oaks is a 20-bed community residential program providing 24/7 on-site support for men recovering from alcohol and other substance use disorders. Participation is usually 6 months and focuses on one's recovery and employment. Supportive Services are available in the community and include referrals for outpatient services, educational and vocational, mental health and medical providers. Community support groups are readily available and clients are encouraged to attend.

Eligibility Requirements:

- Must have a primary substance use disorder diagnosis
- Must be 18 years or older
- Must be male as it is a male residence

What's required to be determined eligible for admission:

- The prescreen referral form
- A Drug and alcohol history review, also known as a comprehensive evaluation
- Once the prescreening form and documentation is received you will be contacted by an intake specialist to complete a phone screen and determine if this is the correct level of care and if you are eligible for admission
- Your case will be reviewed and if eligible you will be given a tentative bed date or placed on our waiting list
- Please feel free to contact us regularly to see where you are on the waiting list

Paperwork required to begin the admission process is as follows:

- A recent physical
- The results of current blood work to include: CBC, US, COMP, and PPD
- A current list of your medications
- Legal information to include: probation reports, pending charges, designation of mandate for treatment, etc.
- Documentation of Public Assistance or other financial resources.

All referral forms should be sent to:

Twin Oaks Program Supervisor

Twin Oaks Community Residence

75 Oak Street

Plattsburgh, NY 12901

Phone: 518-562- 8119, fax: 518-562-8126

To expedite the referral, fax or email to: fax: 518-562-8126 email: sgregory@bhsn.org

hjubert@bhsn.org

It is also helpful to contact the Program Supervisor: Beryl(Sue) Gregory, CASAC

Or Senior Counselor: Heather Jubert, CASAC at the number listed above should you have questions.

PREADMISSION SCREENING INSTRUCTIONS: Complete prior to admission. Please include copy of psychosocial evaluation, history and physical and bloodwork and recent PPD results	Name (Last, First, MI) Date Referred SS Number Date of Birth Gender M☐ F☐ TWIN OAKS COMMUNITY RESIDENCE Phone: 518-562-8119 fax: 518-562-8126

ADDRESS:_____ COUNTY:_____

CITY, STATE, ZIP:_____

PHONE:_____ MARITAL STATUS:_____ LIVING WITH:_____

REFERRED BY:_____

AGENCY:_____ PHONE:_____

REASON FOR REFERRAL:_____

_____

_____

EMPLOYER:_____

ADDRESS:_____

MEDICAL INSURANCE: Yes ☐ No ☐ CARRIER AND #:_____

PUBLIC ASSISTANCE?_____ County of Residence? _____

MEDICAID: Yes ☐ No ☐ Medicaid #_____ Preauthorization Required Yes ☐ No ☐

OTHER HEALTH INSURANCE

LEGAL: Parole ☐ Probation ☐ DWI ☐ Drug Court ☐ Family Court ☐ Referred ☐ Charges Pending ☐ None ☐

SUPERVISING OFFICER:_____ PHONE:_____

COURT NAME: _____ PHONE_____

Registered Sex Offender: Yes ☐ No ☐ If yes, level: 1☐ 2 ☐ 3☐

Is the patient a member of a treatment priority population? Yes ☐ No ☐

Pregnant I.V. ☐ Pregnant ☐ I.V. Drug User ☐

SUBSTANCE USE AND TREATMENT HISTORY

Substance Use History

How long has substance use been a problem? _____

Substances Used: _____

Frequency of use: _____

Last use: _____

Active withdrawal? Yes ☐ No ☐

Treatment History

☐ Inpatient: _____

☐ Outpatient:_____

☐ Detox:_____

☐ Medication Assisted Treatment (Include Prescribers Name and Contact Information):

_____

MEDICAL AND PSYCHIATRIC HISTORY

MEDICAL HISTORY

CURRENT PHYSICAL PROBLEMS_____

PPD TEST DATE:_____RESULTS:_____

CHEST X-RAY DATE:_____RESULTS:_____

CURRENT MEDICATIONS:_____

_____

Please send summary and recommendations for any pertinent current or past medical conditions.

PSYCHIATRIC HISTORY

☐ Hospitalized:_____

☐ Outpatient:_____

☐ Suicide History:_____

CURRENT PSYCHIATRIC STATUS:_____

_____

_____

If patient is currently exhibiting psychiatric symptoms, has had suicide intent in the past twelve months, or is currently on psychotropic, anti-anxiety, or antidepressant medication, please provide a psychiatric report with rationale for medication.

SUMMARY OF RECOMMENDATIONS (include diagnosis and treatment recommendations):_____

_____

_____

_____

_____

_____

_____

TRANSPORTATION:_____WITH WHOM:_____

*Please forward us the most recent comprehensive assessment and treatment plan if applicable.

_____

Signature and Title of Person Completing Report Date

Screened by _____

Date