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.

<u>Eligibility Requirements:</u>

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

<u>What's required to be determined eligible for admission:</u>

- 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

<u>Paperwork required to begin the admission process is as follows:</u>

- 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 VIA EMAIL to: AMANDA HANSEN, Sr. Addictions Counselor
Twin Oaks Community Residence
75 Oak Street
Plattsburgh, NY 12901
Phone: 518-562- 8119, fax: 518-907-8104
ahansen@bhsn.org

Referrals may also be submitted via fax or email to: Fax: 518-907-8104

Please contact Amanda Hansen at the number listed above should you have questions.

Revised 11.3.23

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 (Ph): 518-562-8119 (F): 518-907-8104 e**mail:ahansen@bhsn.org**

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):____________

____

____

____

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____

____

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