TWIN OAKS REFERRAL

Twin Oaks is an OASAS Part 820 Reintegration 20-bed community residential program providing 24/7 on-site support for men recovering from alcohol and other substance use disorders. Participation can range from six months or more and focuses on one's recovery and reintegration back into the community. 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 both onsite and offsite services to help with the transition.

Eligibility Requirements:

- Must have a primary substance use disorder diagnosis
- Meet the appropriate level of care based on the OASAS Level of Care Determination Tool.
- Must be males 18 years or older

Determination Process: *In order to determine if a referral is appropriate for Twin Oaks, the following process occurs to determine eligibility.*

- Completed referral form and all accompanying documentation is received and reviewed
- The prescreen referral form completed in its entirety.
- Once the referral is reviewed, applicants and/or referral sources will be contacted by Twin Oaks to schedule a phone screening with the client to determine if this is the correct level of care.
- Upon completion of the phone screening, The application will be reviewed and discussed by the clinical team and applicant/referral source will be notified of decision.
- Twin Oaks is committed to assisting all applicants and referral sources identify and secure appropriate services until applicant is able to be admitted.

Documentation to be included with the referral:

- Recent physical examination.
- Blood work results including CBC, US, Comp, and PPD.
- Current list of all prescribed medications.
- A complete comprehensive assessment, psychosocial evaluation, or other alcohol and other drug history review.
- Psychiatric evaluation *(if applicable)*.
- *If applicable,* a list of all legal information such as: Probation reports, pending charges, designation of mandate for treatment, or any relevant information required to ensure compliance with a legal mandate to treatment.

All referrals should be sent *Via Email* to:

Keith Ritchie, Program Supervisor
Phone: 518-901-4689, Fax 518-562-8126
KRitchie@BHSN.org

AMANDA HANSEN, Sr. Addictions Counselor
Phone: 518-562- 8119, fax: 518-562-8126
AHansen@BHSN.org

Please contact Keith Ritchie or Amanda Hansen at the numbers listed above should you have questions.

Twin Oaks Community Residence Pre-Admissions Screening INSTRUCTIONS: Complete prior to admission. Please include copy of all required documentation listed prior.	**Name (Last, First, MI)**		**Date of Referral**
	Social Security No	**Date of Birth**	**Gender**
	(Ph): 518-901-4689 (F): 518-907-8104 - email: KRitchie@bhsn.org (Ph): 518-562-8119 (F): 518-907-8104 - email: AHansen@bhsn.org		

Street Address: _____ County: _____

City, State, Zip: _____

Phone: _____ Marital Status: _____ Lives With: _____

Referred by:_____

Agency of Referral: _____ Phone: _____

Email Address: _____

Reason for Referral:

Employer: _____

Address: _____

Insurance Information

Medical Insurance: Yes ☐ No ☐ | Carrier: _____ | ID Number: _____

Public Assistance: Yes ☐ No ☐ | County of Residence:_____

Medicaid: Yes ☐ No ☐ | Medicaid (CIN) #:_____ | Preauthorization Required? Yes ☐ No ☐

Legal Involvement (check all that apply): None ☐

Parole ☐ Probation ☐ DWI ☐ Drug Court ☐ Family Court Referred ☐ Charges Pending ☐

Supervising Officer: _____ Phone: _____

Court Name: _____ Phone: _____

Registered Sex Offender: Yes ☐ No ☐ If so, What Level: 1 ☐, 2 ☐, or 3 ☐

If so, are there any housing restrictions in place and what are they?

Does the client meet any of the following *(check all that apply):*

Pregnant IV User Yes ☐ No ☐

Other Pregnant Substance Abuser Yes ☐ No ☐

Other Injecting Drug User? Yes ☐ No ☐

Are there children placed in or in jeopardy of being placed Foster Care? Yes ☐ No ☐

Substance Use History

How long has substance use been problematic? _____

Substances used: _____

Frequency of use: _____

Last use: _____ Is client in active withdrawal? Yes ☐ No ☐

Treatment History

☐ Inpatient: _____

☐ Outpatient: _____

☐ Detox: _____

☐ Medication Assisted Treatment (if so, provider/contact?): _____

Medical History (*Please send summary and recommendations for any pertinent current or past medical conditions)*

Current Physical Ailments: _____

PPD Test Date: _____ Results: ☐ Positive or ☐ Negative

Chest X-Ray Date: _____ Results: _____

Please list any current medications:

Psychiatric History

☐ Hospitalized: _____

☐ Outpatient:_____

☐ History of Suicidal ideation or attempts:_____

Currently Psychiatric Status:

If patient is currently symptomatic, has had suicide intent in the past twelve months, or is currently on psychotropic, anti-anxiety, or antidepressant medication, please provide a psychiatric evaluation with medication recommendations.

Summary of Recommendations (including diagnosis and treatment recommendations)

Name and Title of Person Completing Referral: _____

Date Completed: _____

Please attach the appropriate signed HIPAA Release