

# Harvest House/Casa Cosecha

Tri County Community Health Center

1480 Maple Grove Church Road

Dunn, North Carolina 28334

Voice: 910-567-5020 Fax: 910-567-5022

Client Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
City State Zip code County

Phone # \_\_\_\_\_ 2<sup>nd</sup># \_\_\_\_\_ Insurance Yes \_\_\_ Type \_\_\_\_\_ No \_\_\_

Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_ Employed: \_\_\_\_\_

**Reason for Referral:**

Primary Drug/s of Choice: \_\_\_\_\_ Other drugs used: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

LEGAL: \_\_\_\_\_ Courts Cases Pending: \_\_\_\_\_

**Referral Source Information**

Agency Name: \_\_\_\_\_ Address: \_\_\_\_\_

Person making referral & title: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Comments: \_\_\_\_\_

\*Individual must be competent and eighteen (18) years of age or older

*Drug use of choice	Frequency	Method of Use	Date & amount of Last Use

**Frequency:**  
 0=Drug not used during past month  
 1=Drug used 1-3 times in past month  
 2= Drug used 1-2 times in past week  
 3= Drug used 3-6 times per week  
 4=Drug used daily  
**Method of use:**  
 1= Oral 2=Smoking 3=Inhalation  
 4=injection 5= other

\*Prior treatment for substance abuse and/or detox: YES \_\_\_\_\_ NO \_\_\_\_\_ : if yes, Where and when?

\*History of Mental Illness: \_\_\_\_\_ Psychiatric Treatment History Yes \_\_\_ No \_\_\_

Is Yes give dates (including State Hospitalizations) \_\_\_\_\_

Client Last Name: \_\_\_\_\_

\*Pertinent Medical Information (High Blood Pressure, Heart problems, Recent Surgery's, other):

**Current Medications/Dosages:** \_\_\_\_\_

- Date of Last:**
1. Tuberculosis (PPD) test \_\_\_\_\_ Results \_\_\_\_\_ Action Taken \_\_\_\_\_ Unknown \_\_\_\_\_
  2. Hepatitis B \_\_\_\_\_ Results \_\_\_\_\_ Action Taken \_\_\_\_\_ Unknown \_\_\_\_\_
  3. Hepatitis C \_\_\_\_\_ Results \_\_\_\_\_ Action Taken \_\_\_\_\_ Unknown \_\_\_\_\_
  4. RPR (Syphilis Screen) \_\_\_\_\_ Results \_\_\_\_\_ Action Taken \_\_\_\_\_ Unknown \_\_\_\_\_

**\*ASAM PPC-2R 3.5 Criteria**

(The client must meet one of the following criteria, in each dimension in order to be appropriate for treatment at Harvest House)

**Dimension 1**

1. \_\_\_\_\_ The individual has no signs or symptoms of withdrawal, or his or her withdrawals needs, can be safely managed in a Level III.5 setting and do not require 24 hour medical or nurse monitoring.

**Dimension 2**

1. \_\_\_\_\_ Biomedical problems, if any are stable and do not require 24-hour medical or nurse monitoring, and the resident is capable of self-medicating.
2. \_\_\_\_\_ A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. The problem requires medical monitoring, which can be provided by the program or through an established arrangement with another provider.

**Dimension 3**

1. \_\_\_\_\_ Individual's Psychiatric condition is stabilizing. However despite his or her best efforts is unable to control their use of alcohol or other drugs and/ or antisocial behaviors, with attendant probability of harm to self or others as evident by: \_\_\_\_\_
2. \_\_\_\_\_ The individual demonstrates antisocial behavior patterns as evident by: \_\_\_\_\_
3. \_\_\_\_\_ The individual demonstrates repeated inability to control his or her impulses to use alcohol or other drugs and/or to engage in antisocial behavior, and in imminent danger of relapse, with attendant likelihood of harm to self or other or property as evident by: \_\_\_\_\_

**Dimension 6**

1. \_\_\_\_\_ The individual has been living in an environment that is characterized by a moderately high risk of repetition of physical, sexual or emotional abuse, or substance use so prevalent that the individual is assessed as being *unable* to achieve or maintain recovery at a less intensive level of care as evident by: \_\_\_\_\_
2. \_\_\_\_\_ The individuals social network includes regular users of alcohol or other drugs, such that recovery goals are assessed as *unachievable* at a less intensive level of care as evident by: \_\_\_\_\_

**Diagnosis** Axis I \_\_\_\_\_

Axis II \_\_\_\_\_ III \_\_\_\_\_ IV \_\_\_\_\_

\_\_\_\_\_  
Signature & title of person completing referral information on page 1 and 2

\_\_\_\_\_  
Date

**For Use By Harvest House:**

\_\_\_\_\_  
\*Staffing date

\_\_\_\_\_  
Staffing Counselor(s) Initials

Acceptable for Program Yes \_\_\_\_\_ No \_\_\_\_\_ In No indicate briefly reason \_\_\_\_\_ Bed Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Person Accepting Referral

\_\_\_\_\_  
Date

Date (s) of Contact with Client \_\_\_\_\_