

REQUEST FOR ADMISSION

Central Intake Department Fax Number: (775) 738-2625

Please circle your facility preference and it will be taken into consideration.

CPC: ___ DETOX: ___ INPATIENT: ___ Date: _____ Time: _____

Person Calling: _____ Relationship: _____
 Client Name: _____ Referral Source: _____

(____) _____ (____) _____ (____) _____
 Caller's Phone Number Client's Home Phone Client's Cell Phone

Address: _____
 P. O. Box or Street City State Zip Code

How long at this address? (months/years) _____ Are you homeless? _____ For how long? _____
 Age: ___ DOB: _____ Social Security #: _____ - _____ - _____ Male: _____ Female: _____

List all substances client is using: _____

Date of Last Use: _____ Are you an IV drug user? Yes: _____ No: _____

ALCOHOL/DRUGS USED	AGE OF FIRST USE	NUMBER OF DAYS YOU HAVE USED IN THE LAST 30 DAYS	HOW MANY YEARS HAVE YOU USED?	DAILY CONSUMPTION AMOUNT	METHOD OF USE

Dose the client Smoke or Chew Tobacco? (Please circle) Yes No Is the client experiencing withdrawal symptoms? (Please circle) Yes No

List symptoms: _____

IS THE CLIENT CURRENTLY USING METHADONE OR SUBOXONE: YES NO

Has the client ever used methadone: (Please circle) Legally Illegally Never Liquid or Tablet Dose: _____ Date taken: _____

Has the client ever used Suboxone: (Please circle) Legally Illegally Never Dose: _____ Date taken: _____ From Where: _____

Medical Conditions: _____

All Medications	Reason	Prescribing Doctor

List All Allergies (Medications, Animals and Foods): _____

Seizures: (Please circle) Yes No If yes: Date of last seizure: _____ Cause: _____

Mental Health Concerns: _____

Is client suicidal: Yes _____ No _____ If Yes explain: _____

Has client had any suicide attempts: (Please explain) _____

Is the client any of the following: (Please circle) Incontinent Yes No Pregnant Yes No Combative/Violent Yes No

Has the client been convicted of a violent crime: _____

Were they under the influence at the time: _____ Which substance: _____

Has the client been convicted of a sexual crime: _____

Does the client have any legal involvement currently: _____

Is the client covered by any of the following: (Please circle) Health Insurance: Yes No Medicaid: Yes No
(If yes to either please turn form over and fill out insurance information)

FOR STAFF USE ONLY

Bert Called: _____ *Approved Denied*
 Barbara Called: _____ *Approved Denied*
 Amanda Called: _____ Policies: _____
 Co-Pay: \$ _____ Med/Supportive Services: \$ _____
 VLT: Deb Called: _____ *Approved Denied*

Client Signature _____ Date _____

INSURANCE INFORMATION

Insurance Company: _____
Medicaid ID #: _____
Member ID #: _____ Group #: _____
Prior Authorization / Pre-Certification Phone #: _____
Copy of card: _____

INSURED'S INFORMATION

Insured's Name: _____ Relationship to client: _____
Insured's SSN: _____ - _____ - _____ Insured's Date of Birth: _____
Insured's Address: _____
City: _____ State: _____ Zip Code: _____
Insured's Telephone Number(s): _____
Insured's Employer: _____

FOR BILLING STAFF USE ONLY

INSURANCE CONTACT INFORMATION

Pre Authorization: DETOX RESIDENTIAL

Date Called: _____ Name of Representative: _____ Ref #: _____
IN Network Provider: _____ Deductible Amt: _____
Premiums Paid Through: _____ Cobra Available: _____
CO-PAY REQUIRED: _____ Expected Patient Out of Pocket Expense: _____
Claims Address: _____
Substance Abuse Benefits Available: _____

Immediate Clinical & Initial Approval

Client Arrival Date and Time: _____ Admitted to: DETOX RESIDENTIAL
Assessment Completed: _____
Insurance Contacted: _____ Representative: _____
Approval Received Through: _____
Written Confirmation received: _____
Date of next review: _____

Notes: _____