De Paul Treatment Centers
1312 SW Washington St.
Portland, OR 97205
Main (503) 535-1151
Email kellie.fellen@depaultc.org

De Paul Treatment Centers Residential Referral Packet

General Information

- If your client resides in the Clackamas, Multnomah or Washington county areas, please direct them to call our facility at (503) 535-1151 to speak to Treatment Access Specialist to receive an over the phone assessment to determine if they are appropriate for our residential program. If available, please fax a drug & alcohol ASAM assessment and medical/mental health records along with this Referral Packet. This will make admissions or placement on the residential waitlist much quicker.
- For Clients ***not residing*** in the Clackamas, Multnomah or Washington please fax this Referral Packet and any additional information requested below to: (503) 535-1163.
- **All referrals require the client to complete an Adult Residential Engagement form from this packet.**
- Hospital referrals must also have medical records faxed with the packet and a discharge medication list at least 24 hours in advance of appointment.
- We do not allow most controlled substances or sedatives in our facility: benzos, Flexeril, tramadol, diphenhydramine, Sudafed, ambien, stimulants, barbiturates. Please contact Kellie Fellen for more information about policies regarding buprenorphine/naloxone.
- Clients must arrive with a physical supply of all prescribed medication in the original pharmacy container with a valid, current label from their current medication list.
- Please review our website for personal items/clothing to bring for residential. We do not have storage for any additional items.
- We will contact you after receiving the required forms and records. You must speak with an intake specialist to confirm appointment availability.
- Any questions please call Kellie Fellen at (503) 535-1164.

Referring Provider/Agency Information

- In order for us to confirm patient admission status, please complete the ROI beginning on the next page including type of information to be shared.

Name of Referring Hospital/Facility/Agency including Department/Team Name:	
Name of Contact Person Making Referral:	**Phone:**
Estimated Hospital/Facility Discharge Date:	
Notes:	

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Adult Residential Engagement Form

Clients referred from residential, inpatient or who reside outside of tri-county area MUST complete this form to be considered for a residential appointment. All other clients must attend Treatment Readiness Screening Group on Fridays at 2pm.

Initial Screening

Has the client been charged with a sex offense? ☐ Yes ☐ No

Do you need assistance performing normal activities of daily living (toileting, medication administration, showering)? ☐ Yes ☐ No

Residential clients are required to go up and down three flights of stairs several times a day for groups and classes. Is this something that will be an issue for you? ☐ Yes ☐ No

If you answered "Yes" to any of the questions above, **STOP**, we cannot take a referral for this patient

General Information

Date: _____ **SSN:** _____

First Name: _____ **MI:** _____ **Last Name:** _____

DOB: _____ **Age:** _____ **Contact number:** _____

Gender: ☐ Female ☐ Male ☐ Trans Female/Trans Woman/Affirmed Woman
☐ Genderqueer/Gender Non-Conforming ☐ Trans Male/Trans Man/Affirmed Man
☐ Agender/Without Gender ☐ Declined ☐ Additional Category: _____

What are your reason for wanting residential treatment? _____

What is going to be different for you if you go to residential? _____

What do you plan to do when you finish treatment? _____

Drug(s) of Choice: _____ **Method of use:** _____

Date of last use: _____ **What's the longest you were sober in the last year:** _____

How many days per week do you usually use:

Alcohol: _____ out of 7 days Benzodiazepines: _____ out of 7 days

Opioids: _____ out of 7 days Meth/Amphetamines: _____ out of 7 days

Other: _____ out of 7 days

Do you have active withdrawals from alcohol, opiates or benzos? ☐ Yes ☐ No

Any IVDU is last 30 days? ☐ Yes ☐ No

Do you know anyone working at DP or any other clients here? _____

Will you or your family need interpretive services (language, hearing, other)? ☐ Yes ☐ No Specify: _____

Emergency Contact

Name: _____

Address: _____

Telephone: Home: _____ **Cell:** _____

Relationship: _____

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Medical Information

Do you take or are you supposed to take prescription medications? ☐ Yes ☐ No *if yes*, list:

Medication Name and Indication	

Do you have or ever had any of the following? Please specify next to the box.

☐ Heart Disease ☐ Arthritis ☐ Migraines ☐ Stroke
☐ Lightheadedness ☐ Diabetes ☐ Tuberculosis ☐ Hernia
☐ Cancer ☐ Ulcers ☐ High Blood pressure ☐ Liver Disease
☐ Abscesses ☐ Head Injury ☐ Shortness of Breath ☐ Kidney or Thyroid Disease
☐ HIV ☐ Hepatitis ☐ Lung Disease (COPD, Asthma, Emphysema, Bronchitis)
☐ Other: _____

Seizures? ☐ Yes ☐ No *if yes*, what was the date of your last seizure: _____

Allergies? ☐ Yes ☐ No *if yes,* please list out allergies: _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A (male) *if yes*, what is your due date: _____

Please describe any special medical/dietary concerns: _____

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Mental Health Information

Do you have any mental health issues or concerns?

☐ Anxiety ☐ Bipolar Disorder ☐ Borderline Personality Disorder
☐ Depression ☐ Psychosis ☐ PTSD
☐ Schizophrenia ☐ Trauma ☐ Schizoaffective Disorder
☐ Other: _____

Have you had suicidal thoughts in the past 12 months? ☐ Yes ☐ No

Have you been hospitalized for suicidal thoughts? ☐ Yes ☐ No *if yes*, when? _____

Suicide attempts? ☐ Yes ☐ No *if yes*, when? _____

Do you harm yourself or cut yourself now or in the past? ☐ Yes ☐ No *if yes*, please describe: _____

_____

Have you recently had homicidal thoughts? ☐ Yes ☐ No

Legal Information

Do you have any pending charges/Upcoming Court Dates? ☐ Yes ☐ No *if yes*, please describe: _____

_____

Parole/Probation Officer name: _____ **County:** _____

Parole/Probation Officer phone: _____

Do you have recent or past involvement of any of the following?

Please provide the charge(s) and date(s) if applicable.

Animal Abuse: ☐ No ☐ Yes: _____
Assault: ☐ No ☐ Yes: _____
Fire Starting: ☐ No ☐ Yes: _____
Gang Involvement: ☐ No ☐ Yes: _____
Sex Offenses: ☐ No ☐ Yes: _____
Other: ☐ No ☐ Yes: _____

Does anyone have a restraining order against you or you against them?

☐ Yes ☐ No *if yes*, who? _____

Are there any no contact order(s) in place for anyone?

☐ Yes ☐ No *if yes*, with who? _____