De Paul Treatment Centers Residential Referral Packet
For HealthShare members only

General Information

▶ If your client is not hospitalized, residing in a facility, incarcerated and resides in the Clackamas, Multnomah or Washington county areas, direct them to attend our Treatment Readiness Group on Fridays at 2pm to be screened to be placed on our residential waitlist. If available, please fax a drug & alcohol ASAM assessment and medical/mental health records along with this Referral Packet. This will make placement on the waitlist and admission to residential much quicker.

▶ Clients not residing in the Clackamas, Multnomah or Washington county areas should not attend the Treatment Readiness Group. These clients need to contact Kellie Fellen at (503) 535-1164.

▶ 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.

▶ De Paul is a tobacco-free facility. Smoking, chewing tobacco, vaping and other related products are not permitted. Smoking cessation services and adjunctive therapy through prescription of Nicotine Replacement Therapy are available based on an individual’s needs.

▶ We do not allow most controlled substances or sedatives in our facility: benzos, Flexeril, tramadol, diphenhydramine, Sudafed, ambien, stimulants, barbituates. 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: |
**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: _____________________ |
### Medical Information

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

<table>
<thead>
<tr>
<th>Medication Name and Indication</th>
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**Do you have or ever had any of the following? Please specify next to the box.**

- ☐ Heart Disease
- ☐ Lightheadedness
- ☐ Cancer
- ☐ Abscesses
- ☐ HIV

- ☐ Arthritis
- ☐ Diabetes
- ☐ Ulcers
- ☐ Head Injury
- ☐ Hepatitis

- ☐ Migraines
- ☐ Tuberculosis
- ☐ High Blood pressure
- ☐ Shortness of Breath
- ☐ Lung Disease (COPD, Asthma, Emphysema, Bronchitis)

- ☐ Stroke
- ☐ Hernia
- ☐ Liver Disease
- ☐ Kidney or Thyroid Disease
- ☐ Other: ____________________________

- ☐ 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:** ____________________________

______________________________

______________________________

______________________________
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? ______________________________