McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Ambulatory Treatment Center at Naukeag Self-Referral Packet

NOTE: To be considered for admission application must be complete in full. If you need assistance with the application call 978.756.5100 ask for admissions.

How did you hear about Naukeag: _____

PATIENT INFORMATION

Date: _____

Have you been to Naukeag previously? ☐ Yes ☐ No

Are you being referred by any program or treatment provider? ☐ Y ☐ N (name): _____

Patient Name: _____ Age_____ Gender: _____ DOB: _____

Address: _____ State/Country: _____ ZIP: _____

Email: _____ Daytime phone #:_____Cell #: _____

Preferred method of contact: ☐ Email ☐ Phone ☐ Cell ☐ All Best time:_____

PRESENTING PROBLEM

Check all boxes that describe issues you are currently dealing with:

☐ alcohol problem ☐ drug problem ☐ depression ☐ anxiety ☐ trauma issues ☐ suicidal ideation
☐ eating disorder ☐ relationship conflict ☐ housing/homelessness ☐ anger management ☐ ADD

☐ work issues ☐ school issues ☐ grief issues

Briefly state why you are considering admission to Naukeag at this time:

_____
_____
_____
_____

CURRENT TREATMENT

Do you have current treatment providers? ☐ Y ☐ N Do you have a psychiatric diagnosis? _____

Name/Agency: _____ ☐ therapist ☐ psychiatrist ☐ IOP ☐ partial Phone: _____

Name/Agency: _____ ☐ therapist ☐ psychiatrist ☐ IOP ☐ partial Phone: _____

PAST TREATMENT (Addiction and Mental Health)

Treatment Type	# of admits	Facility Name (of most recent treatment)	Dates
Detoxification			
Inpatient psychiatric			
Residential			
Halfway house			
Sober house			
Intensive outpatient (IOP)			
Outpatient therapy			
Couple/family therapy			
Suboxone, Methadone maintenance			

Patient Name: _____

DRUG USE HISTORY

Primary Drug(s): _____ **Secondary:** _____

✓ if used in the past year	Drug	Age First Use	Last Use	Frequency	Amount
☐	Alcohol				
☐	Amphetamines				
☐	Benzodiazepines (Klonopin, Xanax, Valium Ativan)				
☐	Cocaine				
☐	Fentanyl				
☐	GHB				
☐	Hallucinogens (mushrooms, LSD, PCP, DXM)				
☐	Heroin				
☐	Inhalants				
☐	Ketamine				
☐	Marijuana				
☐	MDMA (Ecstasy)				
☐	Methadone				
☐	Methamphetamine				
☐	Morphine				
☐	Over the counter (cough syrup, asthma inhalers, laxatives, diet pills, cold medicines, ephedrine, sleeping pills, Benadryl)				
☐	Oxycontin, Oxycodone, Percocet				
☐	Rohypnol				
☐	Steroids (Anabolic)				
☐	Suboxone				
☐	Tobacco				
☐	Other:_____				

MEDICAL

Date of Last Physical:_____

Primary Care Physician:_____ Phone: _____

List any current medical conditions:

Patient Name: _____

Current Medications	Dosage	Reason Taking

RISK FACTORS

History of suicide attempts ☐ No ☐ Yes: _____

Present suicidal ideation ☐ No ☐ Yes: _____

Self-harm (past/present) ☐ No ☐ Yes: _____

Harm to others ☐ No ☐ Yes: _____

Fire-setting ☐ No ☐ Yes: _____

Access to firearms ☐ No ☐ Yes: _____

Trauma history ☐ No ☐ Yes: If yes do you feel that trauma may affect your recovery? ☐ No ☐ Yes

LEGAL

Any current legal charges ☐ No ☐ Yes: _____

On probation ☐ No ☐ Yes: _____

Upcoming court dates ☐ No ☐ Yes: _____

Restraining orders ☐ No ☐ Yes: _____

AFTERCARE PLANS

Housing: ☐ Return Home ☐ Sober House ☐ Residential Program ☐ Friends ☐ Homeless ☐ Other _____

Emergency Placement if needed to leave program unexpectedly:_____

Treatment: ☐ Back to current providers ☐ Partial ☐ IOP ☐ Individual Therapist/Psychiatrist ☐ Group

☐ Another Program ☐ Self Help ☐ Unsure

Any additional comments: _____

_____

*Upon completion of this application, fax to: 978.756.5150

Ambulatory Treatment Center at Naukeag Self-Referral Packet
Pre-Admit Form

Patient Name: _____ **Date:** _____ **Program:** ☐**ART or** ☐**PHP**

Patient DOB: _____ Age: _____ Telephone #:_____

Address: _____ City/State: _____ Zip: _____

Primary Insurance: _____ Telephone #:_____

Insurance ID#: _____ Group # (if applicable): _____

*Subscriber Name: _____ *Subscriber DOB: _____

Secondary Insurance: _____ Telephone #:_____

Insurance ID#: _____ Group # (if applicable): _____

*Subscriber Name: _____ *Subscriber DOB: _____

PHARMACY INFORMATION

In order to be prescribed medication at Naukeag the following information is <u>required</u>. If you don't have a prescription card call your pharmacy and they will be able to give you the information.

Cardholder ID: _____ RxBIN: _____

RxGroup: _____ Person Code: _____ Pharmacy: _____

Town: _____ Phone Number: _____

Do you have any allergies? _____

You are responsible for all co-pays which you may pay in cash or by credit card. The card number can be called into the pharmacy.

STOP HERE

<u>Insurance Information</u>