Dear Referent,

Please take a moment to complete the referent form below, providing as much information as possible so as to help expedite the admission process. Once complete, fax the form to our admissions team at 802.222.4868. Should additional information be necessary, an admissions team member will contact you. For additional information pertaining to our men's, woman's or transitional aged youth program, please visit www.vvista.net/resources, where you'll find handbooks with overviews for each for each Valley Vista programs.

Please do not hesitate to contact the Admissions office at 802.222.5201 x101, the appropriate program manager, our treatment director or our clinical director with any potential questions pertaining to a possible admission for either a transitional aged youth (16 – 22 year old male) or adult female or male.

We look forward to working with you in the near future.

Amanda Hudak, MS, LADC, MAC
Treatment Director
802.222.5201 x411

Dawn Taylor, MA, LADC, CS
Clinical Director
802.222.5201 x319

Nicole Mitchell, MA, LADC, CATP, RRYT
Men's and Young Adult Program Manager
802.222.5201 x322

Kelly Mitchell, MA, M.Ed, LCMHC
Women's Program Manager
802.222.5201 x341

Johannah Cacio, RN
Director of Nursing
802.222.5201 x312

Admissions Referent Form

VALLEY VISTA

Date of Screenin g: _ _ _ _ _

Time of Screenin g: _ _ _ _ _ _

Initials of perso n completing Screening: ______________

Advance Directive: Y N

Admit. Invent. Sheet Rev.? Y N

Methadone: y N

Buprenorphine: y N

Suboxone: y N

Subutex: y N

Prescribing Doctor: ____________________

(_) _ - _________

First: _ _ _ _ _ _ _ _ _ _ _ Middle Initial: Last: _ _ _ _ _ _ _ _ _ _ _ _ _

Address: ________________________________

City: - - - - - - - - - - State: ______________ Zip: _ _ _ _ _ _ _

Home Phone: ___________ Cell: ___________ Work: ___________

DOB: _______ Age: _ _ _ _ Social Security #: ___ _ _______ ________

Sex: (02) Female (01) Male

Emergency Contact: ______________________ Relationship: _ _ _ _ _ _ _

Home Phone: ___________ Cell: ___________ Work: ___________

Principal Referral:

1	Individual , including self or family	5	Employer/EAP
2	Alcohol/Drug Abuse Care Provider	6	Other Community Refe1rnl
3	Other Health Care Provider	7	Cami/Criminal Justice Refe1rnl
4	School/Education	97	Unknown

Referral Contact Information:

PRIMARY:

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Agency: ____________________

Address: _

City: __________ State: _ _ _ _ _ _ _ _ _ _ Zip: __________

Phone: ___________ Fax: __________

SECONDARY:

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Agency: _ _ _ _ _ _ _ _ _ _ _ _ _

Address: _

City: ___________ State: ___________ Zip: __________

Phone: ___________ Fax: _ _ _ _ _ _ _ _ _ _

Adolescents Only:

DCF Probation: Yes No Probation Worker: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Custody: DCF or Parents Names: _____________________

Adopted? Yes or No Names: _____________________

Payer Source:	A	Blue Cross/Blue Shield	F	Conections Contract
	B	Private Insurance	G	SRS Contract
	C	State (ADAP)	H	School Contract
	D	Medicaid/MedicareNHAP	I	Other/Unknown
	E	Private Contract (Federal)		

Primary:_____ **Secondary:** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Active Drug Use:

01-None
2 - Alcohol
3 - Cocaine/Crack
4 - Marijuana/Hashish
5 - Heroin
6 - Non-Prescription Methadone
07 - Other Opiates / Synthetics
8 - PCP
9 - Other Hallucinogens
10- Methamphetamines
I I - Other Amphetamines
12 - Other stimulants
13 - Benzodiazepine
14 - Other Tranquilizers
15 - Barbituates
16 - Other Sedative s/Hypnotic s
17 - Inhalants
18 - Over the counter drugs
20-Other
96 - Not Applicable
97 - Unknown
98 - Not Collected

	Primary	Secondary	Tertiary
Substance:			
Date of last use:			
Route:	1 - Oral 2 - Smoking 03 - Inhaling 04 - Injection 20 - Other 96 - Not Applicable 97 - Unknown 98 - Not Collected	1 - Oral 2 - Smoking 03 - Inhaling 04 - Injection 20 - Other 96 - Not Applicable 97 - Unknown 98 - Not Collected	1 - Oral 2 - Smoking 03 - Inhaling 04 - Injection 20 - Other 96 - Not Applicable 97 - Unknown 98 - Not Collected
Frequency:	01 - No use in past month 02 - 1-3 times in past month 03 - 1-2 times in past week 04 - 3-6 times in past week 05 - Daily 96 - Not Applicable 97 - Unknown 98 - Not Collected	1 - No use in past month 2 - 1-3 times in past month 03 - 1-2 times in past week 04 - 3-6 times in past week 05 - Daily 96 - Not Applicable 97 - Unknown 98 - Not Collected	01 - No use in past month 02 - 1-3 times in past month 03 - 1-2 times in past week 04 - 3-6 times in past week 05 - Daily 96 - Not Applicable 97 - Unknown 98 - Not Collected
Amount:			
Age of first use:			

Drug & Alcohol Treatment Histon::

Out Patient: When:_____ Where:_____

When:_____ Where: _____

Detox: When:_____ Where:_____

When:_____ Where: _____

lnpt./Res.: When: Where:_____

When:_____ Where: _____

Medical History:

Are you Pregnant? 1 -Yes 2-No Unsure

If yes how long: _ - - - - - - Due Date: _ - - - - - -

Have you seen a Doctor? Yes No Doctors Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

History of Seizures? Yes___ No Drug Related? Yes No

Notes: _

Allergies: Yes No If yes please list: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Current Medical Problems? Yes No

If yes please describe: _

Any Medical Diagnosis: _

Cun ent Prescribed Medications: (list Meds & Dosages) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Not Prescribed Medication: _

Treating Physician and/or Agency: _

Mental Health/Psychiatric History

Any current Mental Health problems? Yes No

If yes please describe: _

Treating Agency:____ Diagnosis: _ _ _ _ _ _ _ _ _

Previous Mental Health Treatment or Problems: _

Treatment History:

When: _ _ _ _ _ _ _ _ _ _ _ _ _ Where: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

When: _ _ _ _ _ _ _ _ _ _ _ _ _ Where: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Cunent Prescribed Medications: (list Meds & Dosages) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Past Use of Medications: _____

Any History of the Following:

			Describe
Hallucinations	y	N	_____
Suicide Ideation	y	N	_____
Suicide Plan	y	N	_____
Suicide Attempt	y	N	_____
Eating Disorder	y	N	_____
Violence	y	N	_____
Fire Setting	y	N	_____
Sexual Assault/Abuse	y	N	_____
Cutting/Burning	y	N	_____

If yes to any of the above - request records if available (needs to be reviewed by Executive Director/ Program Director)

_____

_____

_____

Legal History

Charges Pending: Yes No Describe: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_____

Past or Present Incarceration: Yes No Date of Incarceration: _ _ _ _ _ _ _ _ _

DWI Mandate: 1 -Yes 2 -No # of atTests in last 30 days:_____

Attorney Name: _____

Address: _

City: _ _ _ _ _ _ _ _ _ State: _ _ _ _ _ _ _ _ _ _ Zip: _ _ _ _ _ _ _ _ _

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

Probation/Police Officer: _

Address: _

City: _ _ _ _ _ _ _ _ _ State: _ _ _ _ _ _ _ _ _ _ Zip:_____

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

Mandated to Treatment: Yes No By When: _ _ _ _ _ _ _ _ _ _ _

Number of Dependents: ___ _ Education: Mothers Maiden Name: __ __ __ __ __ __ __ __

School: _

Transaction Type: A Admission R Re-Admission

Race:			Ethnicity:		
	01	Alaskan Native		01	Puerto Rican
	02	American Indian		02	Mexican
	03	Asian or Pacific Islander		03	Cuban
	04	Black or African American		04	Other Hispanic
	05	White		05	Not of Hispanic Origin
	20	Other		97	Unknown
	97	Unknown		98	Not Collected
	98	Not Collected			

Living Arrangement		
	01	Homeless
	02	Dependent
	03	Independent

Employment:		
	1	Employed Full Time (35 or more hours per week)
	2	Employed Part-Time (less than 35 hours per week)
	3	Unemployed (looking for work or laid off)
	4	Not in Labor Force (has not looked for work in last 30 days)
	5	Student
	6	Retired
	7	Disabled
	8	Incarcerated
	9	Homemaker

Client Type: 2 Client

Provided Service:		
	02	Detoxification - Free Standing Residential
	04	Rehab/Residential - Long Te1m >30 days

Ctment Medication List	Drug & Alcohol Screening ___	Meth/Bupe/Sub Letter ___
Immunization Record	Hospitalization Records	DCF Placements
Psych Reports	IEP	

Revised 9/23/08 MLD 10/6/09 MLD

Valley Vista

ADMISSION PROGRESS NOTES

(Date & Time for each entry)

Name: _ _ _ _ _ _ _ _ _

Insurance: _ _ _ _ _ _ _

9/26/08 rev. MLD