

REFERRAL TO ORIENTATION – Substance Abuse – HARBEL (revised 10/9/2020)

Today's Date: \_\_\_\_\_ HARBEL Staff taking call: \_\_\_\_\_  
Caller: Self  Referral Source  other \_\_\_\_\_ Are you a Re-Admit: No  Yes  ID# \_\_\_\_\_

**\*If yes, pull up client in ETO to see if client is eligible or not. If not eligible or information in ETO is unclear/ states requires clinical review - refer to clinical director before scheduling intake. Person should be told to call back in 48 hours if clinical director is not able to screen case at time of call. Please complete form before referring to clinical director. If clinical director is not expected to be available within 48 hours, another supervisor or team leader can be assigned to review.**

If yes, was client previously here for DV charges? No  Yes  If yes, when: \_\_\_\_\_

**\*\*If yes, ETO should be checked as indicated above and person must be scheduled to meet with DV team before an intake is scheduled. If person is unable/unwilling to meet with DV team, they should be referred to clinical director.**

**\*\*\*If yes and person here previously, and their previous balance exceeds \$10, the person must pay their full balance before being scheduled for readmission. They can speak with the program director or clinical director to discuss a payment plan but should not be scheduled for an intake unless the program director or clinical director has approved the re-admission.**

Client's Name: \_\_\_\_\_ Male  Female  Adult  Adolescent

Parent /Guardian Name(s) if adolescent: \_\_\_\_\_ Relationship \_\_\_\_\_

D.O.B. \_\_\_\_\_ SS#: \_\_\_\_\_

Homeless Yes  No  **\*If homeless, have clinical director review before scheduling intake.\***

Address: \_\_\_\_\_ Baltimore, MD Zip Code \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

What is best time of day to contact you (Morning, afternoon, or evening?) \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Number of Emergency Contact \_\_\_\_\_

Veteran: Yes  No  Marital Status: \_\_\_\_\_

Do you have Children? Yes  No  If yes, how many children do you have? \_\_\_\_\_

Is client employed? Yes  No  Where \_\_\_\_\_

Is client a current student? If Yes  Yes  No  Grade \_\_\_\_\_ Where \_\_\_\_\_

Have you completed High School? Yes  No  If No, do you have a GED? Yes  No  If No, are you interested in obtaining your GED? Yes  No

Are you insured? Yes  No  If uninsured: Monthly Income: \_\_\_\_\_ Family Size: \_\_\_\_\_

**(If they are Uninsured and reporting income, proof of income is due at time of Intake Assessment.)**

If insured: Medicaid  MCO \_\_\_\_\_ MA # \_\_\_\_\_

Other  Insurer \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Provider Phone Number \_\_\_\_\_

**\*\*\*Caller should be informed that we cannot determine what their insurance will cover, and encourage them to check their benefits/co-pay. Also inform the caller that they will be responsible for any changes not covered by insurance. \*\*\*Uninsured clients should be advised to visit Healthcare Access Maryland located at 1 N. Charles St., Baltimore, MD 21201 or call 1-855-288-3667 to apply for health insurance.**

**Reason for Referral: Substance Abuse Domestic Violence Both \*\*If it is a DV referral and they deny Substance Abuse, inform the caller we do not accept DV referrals only .If person needs a letter after being told this, they need to be referred to clinical director , another supervisor, or case mgr.**

**Briefly Explain Reason person needs treatment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referral Contact: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Referring Agency information: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_, MD Zip Code \_\_\_\_\_ Email address of referral source: \_\_\_\_\_

Date of Intake Appointment: \_\_\_\_\_ Time of Intake Appointment: \_\_\_\_\_

**Please Complete- Mandatory Information as we have to report to state:** \_\_\_\_\_ = # of days waiting to enter treatment  
(Calculate as number of days from initial phone call to first available appt- regardless of whether client accepts first available appt)

1. How often do you drink alcohol? \_\_\_\_\_  
When you do drink, how much and how often? \_\_\_\_\_  
In last two weeks, what is longest period of time you have gone without drinking? \_\_\_\_\_  
When you are not drinking, do your hands shake, do you feel sick, or have other symptoms that go away when you have a drink?  
If Yes, please explain: \_\_\_\_\_

**( If person has not gone 48 hours in last two weeks without drinking and /or is reporting physical symptoms of withdrawal, case should be reviewed by clinical director or other supervisor before scheduling intake as there may be detox or other issues to be explored)**

2. What other substances have you used in the last 6 months? \_\_\_\_\_  
Of those, which have you done in the last 30 days? \_\_\_\_\_  
How much and how often? \_\_\_\_\_

3. Are you being prescribed methadone or suboxone? Yes  No   
( If person reports using opiates ( heroin), prescription drugs such as Percocet or suboxone, or methadone in last two weeks- the case should be reviewed by clinical director or other supervisor before scheduling intake. High quantities of daily use of cocaine or crack or PCP should also be reviewed by a supervisor before scheduling. **Clients who are in methadone or suboxone programs are not eligible for admission/intake appointments- although persons who are receiving suboxone from a community physician are eligible for admission.** THC use does not require a review prior to intake regardless of frequency. )

4. Have you ever been enrolled in any substance abuse treatment before? Yes  No   
Where and when: \_\_\_\_\_

**If person indicates recent inpatient/residential or detox, they should be scheduled for an intake within 1 to 3 days as a priority case.**

5. Has the person ever been treated for a mental health/ psychiatric problem? Yes  No   
a. If yes, by whom, and for what? \_\_\_\_\_  
Is this person currently being treated? Yes  No  On psychiatric medication Yes  No

**If person reports schizophrenia or other severe mental illness for which they are not taking medication or receiving treatment, case should be screened by clinical director or other supervisor.**

b. If on medication, who is prescribing the medication? \_\_\_\_\_

c. Are there current mental health issues we should be aware of? Yes  No   
If yes, explain briefly-include diagnosis/symptoms if possible: \_\_\_\_\_

d. Is this person currently experiencing suicidal thoughts? Yes  No

**If yes; clinical director, clinical supervisor, or clinical senior staff should be given the call immediately. If clinical staff are not immediately available person can be given number for Baltimore City Crisis Response 410-433-5175 or Baltimore County Crisis Response 410-931-2214.**

e. Has person ever experienced suicidal thoughts? Yes  No

f. If person has experienced suicidal thoughts previously- when and how often? \_\_\_\_\_

**Recent thoughts or frequent thoughts should be brought to the immediate attention of the clinical supervisor or senior clinical staff at the time of the call. As above, crisis response numbers can also be given.**

6. Has this person ever lost their temper or gotten into an argument while under the influence of drugs or alcohol? Yes  No   
Explain: \_\_\_\_\_

7. Has this person ever experienced any of the following?  
a. Blackouts Yes  No  When \_\_\_\_\_  
b. History of overdose Yes  No  Details \_\_\_\_\_  
c. Seizures Yes  No  When \_\_\_\_\_

History of seizures with current alcohol use should be screened further by clinical director before scheduling intake

d. Felt sick, shakes, or depressed when not using Yes  No  When \_\_\_\_\_  
e. Tested positive for TB or received TB treatment Yes  No  When \_\_\_\_\_  
f. Hepatitis or Liver Disease Yes  No  Type \_\_\_\_\_  
g. HIV infection Yes  No  When \_\_\_\_\_

**\*\* If person indicates HIV infection, they should be scheduled for an intake within 1 to 3 days as a priority case.**

Does person have any current general health concerns or allergies? Yes  No   
Explain: \_\_\_\_\_

8. Is the person currently pregnant? Yes  No  Prenatal Care? Yes  any  Due Date: \_\_\_\_\_

**If pregnant, person should be scheduled for an intake within 1-3 days as a priority case.**

9. Has person been arrested or have any pending charges/legal problems? Yes  No   
Explain Briefly: \_\_\_\_\_

10. Is person currently on  Pretrial  Probation  Parole

11. Have you ever been accused/ charged with a sexual assault charge? Yes  No

**(Explain if this is yes, we cannot accept due to treating children/adolescent clients in the same facility)**

**Any Additional Notes/ Information to be considered:**

\_\_\_\_\_  
\_\_\_\_\_