

# ROCHESTER REGIONAL HEALTH

**About Us:** Rochester Regional Health Inpatient Chemical Dependency is a voluntary residential substance use disorder treatment facility. Unlike inpatient psychiatric services, our facility does not utilize restraints, emergency psychotropic intramuscular medications or ligature risk prevention measures which ensure the safety of patients that struggle with some acute mental health conditions. As a voluntary program, patient success is dependent upon some level of internal motivation and an ability to socialize with other participants while they share living spaces and are in continuous contact with others throughout the day.

As a therapeutic program, clients will be actively learning recovery skills and motivation to enable them to be successful in outpatient chemical dependency treatment or maintain their medication assisted treatment post discharge. In addition, our inpatient rehabilitation unit operates as a residential facility rather than a traditional hospital floor. Our medical staff is able to manage mild to moderate withdrawal and other medical conditions which would be typically managed in an outpatient setting. As a residential unit we do not have the ability to provide IV fluids or medications, bedside nursing care, or other intensive medical services.

Patient safety is our top priority. When reviewing admissions, we attempt to evaluate whether our inpatient program setting would be beneficial to a patient's recovery goals and use this to guide our decision making with regards to patient care. Therefore, it is imperative that we have the most up to date information possible in order to ensure patient safety during inpatient admissions.

Please fill out the attached referral form in its entirety and contact the Central Admissions Team for processing. Any referral forms not completely filled out may be returned and requested to complete in order to safely process for possible admission to one of our three Inpatient Chemical Dependency units. If a patient's situation changes between receipt of this referral and admission, there is a possibility that the patient may not be able to be admitted if their safety is at risk.

Acknowledgement: All items in this form have been filled out in their entirety based on information provided by the patient. I have reviewed these areas with the patient who is fully aware that their admission ability is contingent upon the information in this referral packet.

\_\_\_\_\_  
Signature of referring provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date information provided by client

## Rochester Regional Health Central Admissions Team

Phone: 585-723-7233

Fax: 585-723-7341

Email: [CDInpatientIntakeTeam@rochesterregional.org](mailto:CDInpatientIntakeTeam@rochesterregional.org)

**Referral Agency Information**

Referral Agency: \_\_\_\_\_

Referral Agency Address and Phone Number: \_\_\_\_\_

Representative Name and Contact Information: \_\_\_\_\_

Backup Contact Name and Contact Information: \_\_\_\_\_

**Patient Demographic Information**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

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

Patient Phone Number: \_\_\_\_\_

Backup Phone Number (s): \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Patient's Gender Identity:

- |   |   |
|---|---|
| <input type="checkbox"/> Male – Not Transgender   | <input type="checkbox"/> Transgender – Female to Male |
| <input type="checkbox"/> Female – Not Transgender | <input type="checkbox"/> Transgender – Male to Female |
| <input type="checkbox"/> Transgender – other      | <input type="checkbox"/> Non-Binary                   |
| <input type="checkbox"/> Don't know/not sure      | <input type="checkbox"/> Didn't answer                |

**Unit Preference (please mark rankings 1-3 based on patient choice)**

\_\_\_\_\_ Unity Chemical Dependency 1565 Long Pond Rd Rochester NY 14626

\_\_\_\_\_ Clifton Springs Hospital and Clinic 2 Coulter Rd Clifton Springs, NY 14432

\_\_\_\_\_ Hope Haven 16 Bank St Batavia, NY 14020

## Substance Use

### **SUD Diagnosis Codes (Please check all that apply):**

(ALC) F10.20  (OP) F11.20  (CAN) F12.20  (SED) F13.20  (COC) F14.20  (INH) F18.20  Other: [    ]

### **Use disorder criteria**

1. Use in physically hazardous situations (driving under influence, IV use, etc)
2. Social/interpersonal problems due to use
3. Failure to fulfill work, school, home duties
4. Tolerance
5. Withdrawal
6. Attempts to quit/control use
7. Time spent using
8. Activities given up due to use
9. Ongoing use despite consequences
10. Experiencing cravings
11. Taken in larger amounts of over a longer period of time than intended.

### **Current Substance Use Information (List all applicable in order of severity):**

Substance: \_\_\_\_\_  
Age of first use: \_\_\_\_\_  
Current frequency of use: \_\_\_\_\_  
Length of time in current use pattern: \_\_\_\_\_  
Current amount and method of use: \_\_\_\_\_  
Criteria numbers met (list from above): \_\_\_\_\_  
Any history of withdrawal symptoms (or N/A): \_\_\_\_\_  
Last use date: \_\_\_\_\_

Substance: \_\_\_\_\_  
Age of first use: \_\_\_\_\_  
Current frequency of use: \_\_\_\_\_  
Length of time in current use pattern: \_\_\_\_\_  
Current amount and method of use: \_\_\_\_\_  
Criteria numbers met (list from above): \_\_\_\_\_  
Any history of withdrawal symptoms (or N/A): \_\_\_\_\_  
Last use date: \_\_\_\_\_

Substance: \_\_\_\_\_  
Age of first use: \_\_\_\_\_  
Current frequency of use: \_\_\_\_\_  
Length of time in current use pattern: \_\_\_\_\_  
Current amount and method of use: \_\_\_\_\_  
Criteria numbers met (list from above): \_\_\_\_\_  
Any history of withdrawal symptoms (or N/A): \_\_\_\_\_  
Last use date: \_\_\_\_\_

Substance: \_\_\_\_\_  
Age of first use: \_\_\_\_\_  
Current frequency of use: \_\_\_\_\_  
Length of time in current use pattern: \_\_\_\_\_  
Current amount and method of use: \_\_\_\_\_  
Criteria numbers met (list from above): \_\_\_\_\_  
Any history of withdrawal symptoms (or N/A): \_\_\_\_\_  
Last use date: \_\_\_\_\_

**Substance Use Treatment History (List in order from current or most recent)**  
 \*If currently engaged in a detox facility, please note anticipated completion of detox medications

Provider	Level of Care (IP/OP/Detox/Residential)	Mark if on MAT	Dates	Mark if Current	Completed?
					Yes ___ No ___ N/A ___
					Yes ___ No ___ N/A ___
					Yes ___ No ___ N/A ___
					Yes ___ No ___ N/A ___
					Yes ___ No ___ N/A ___
					Yes ___ No ___ N/A ___

**Psychiatric History**

**Psychiatric Symptom History**

Has the patient ever attempted suicide? YES \_\_\_\_\_ No \_\_\_\_\_  
 If yes, when was the most recent attempt? \_\_\_\_\_  
 What treatment (if any) was provided? \_\_\_\_\_  
 If this person is in the ED or hospitalized have they been cleared by psychiatry? \_\_\_\_\_  
 What were the circumstances of the attempt (under the influence? Chronic suicidality? Method of attempt?) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the patient ever experienced suicidal ideations or non- suicidal self-harm? YES \_\_\_\_\_ No \_\_\_\_\_  
 If yes, when was the most recent experience? \_\_\_\_\_  
 What treatment (if any) was provided? \_\_\_\_\_  
 If this person is in the ED or hospitalized have they been cleared by psychiatry? \_\_\_\_\_  
 What were the circumstances of the experience (under the influence? Chronic suicidal thoughts? Method of attempt – cutting, ingesting foreign bodies, swallowing, intentional overdose, suicidal gestures?) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the patient ever presented as violent/aggressive? YES \_\_\_\_\_ No \_\_\_\_\_  
 If yes, when was the most recent violent/aggressive episode? \_\_\_\_\_  
 What treatment (if any) was provided? \_\_\_\_\_  
 If this person is in the ED or hospitalized have they been cleared by psychiatry? \_\_\_\_\_  
 What were the circumstances of the attempt (under the influence? Chronic violence/aggression? Method of attempt?) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the patient ever experienced hallucinations? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If yes, when was the most recent episode of experiencing hallucinations? \_\_\_\_\_  
 What treatment (if any) was provided? \_\_\_\_\_  
 What were the circumstances of the hallucinations (under the influence? Chronic hallucinations? Type (auditory/visual/command/etc?) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the patient ever experienced delusions? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If yes, when was the most recent episode of experiencing delusions? \_\_\_\_\_  
 What treatment (if any) was provided? \_\_\_\_\_  
 What were the circumstances of the delusions (under the influence? Chronic delusions? Type (delusions of grandeur/somatic/jealous/etc?) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the patient ever experienced paranoia? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If yes, when was the most recent episode of experiencing paranoia? \_\_\_\_\_  
 What treatment (if any) was provided? \_\_\_\_\_  
 What were the circumstances of the paranoia (under the influence? Chronic paranoia?) \_\_\_\_\_

Has the patient ever experienced mania? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If yes, when was the most recent episode of experiencing mania? \_\_\_\_\_  
 What treatment (if any) was provided? \_\_\_\_\_  
 What were the circumstances of the mania (under the influence? Chronic mania?) \_\_\_\_\_

**Psychiatric Treatment History (List in order from current or most recent)**

Provider	Level of Care (IP/OP /Residential)	Dates	Mark if Current	Completed? Yes ___ No ___ N/A ___
				Yes ___ No ___ N/A ___
				Yes ___ No ___ N/A ___
				Yes ___ No ___ N/A ___
				Yes ___ No ___ N/A ___
				Yes ___ No ___ N/A ___
				Yes ___ No ___ N/A ___

**Medical**

\*Please select yes or no for each. If yes, please list all current symptoms

Diagnosis/Medical Condition:	Yes	No	Current Symptoms
<b>Able to ambulate independently</b> (note if uses assistive device)			
<b>Able to perform ADL's independently</b> (bathing, dressing, etc)			
<b>COVID positive test within past 30 days</b> (note date)			
<b>CPAP machine</b>			
<b>Dialysis</b> (note schedule and provider)			
<b>Eating Disorder</b>			
<b>Incontinence of bowel or bladder</b> (note ability to self-manage hygiene)			
<b>IV medications/PICC/Central Line</b>			
<b>Ostomy</b> (note ability to manage independently and hygienically, and access to 5 days' worth of supplies)			
<b>Oxygen dependent</b> (note usage and ability to manage independently)			
<b>PEG Tube/Feeding Tube/Trach</b>			
<b>Pregnant</b> (note trimester and willingness to provide consent for OB provider)			
<b>Prescribed Methadone</b> (note prescriber and intent to continue)			
<b>Prescribed Sublocade</b> (note willingness to receive oral medication on unit, or can receive injection prior to arrival)			
<b>Recent fall/fall risk</b>			
<b>Seizure history</b> (note frequency, last known, and circumstances – i.e. seizure disorder vs due to substance use)			

<b>Self-catheter</b> (note ability to perform independently and access to 5 days' worth of supplies)			
<b>Wound Care</b> (note ability to self-manage, access to supplies, information on dressing changes)			

\*Please list all current medications (including psychotropic), including dosage, frequency, and patient compliance

Medication Name	Dose	Frequency	Compliant	Non-Compliant

Has the patient been admitted to the hospital in the past 6 months? YES \_\_\_ NO \_\_\_  
 If yes, what were the dates of admission and discharge? \_\_\_\_\_  
 What were the circumstances? \_\_\_\_\_  
 Was the patient medically and/or psychiatrically cleared prior to discharge? \_\_\_\_\_

**Social**

Marital/Relationship Status: \_\_\_\_\_  
 Current Living Situation: Alone \_\_\_ Family \_\_\_ Non-related persons \_\_\_ Homeless \_\_\_  
 Is the current living environment a sober environment: YES \_\_\_ NO \_\_\_  
 Is client currently being referred to a Community Residence (HWH): YES \_\_\_ NO \_\_\_  
 If yes, where: \_\_\_\_\_

**Legal**

Does client have current legal charges: YES \_\_\_ NO \_\_\_  
 If yes, describe: \_\_\_\_\_  
 Is client currently on probation or parole (circle one): YES \_\_\_ NO \_\_\_  
 Describe charge: \_\_\_\_\_  
 Is patient willing to provide consent to current legal representative while admitted on an inpatient unit? YES \_\_\_\_\_ NO \_\_\_\_\_