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: 585-723-7366 **Fax**: 585-723-7341 **Email**: 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:

☐ Male – Not Transgender
☐ Female – Not Transgender
☐ Transgender – other
☐ Don't know/not sure
☐ Transgender – Female to Male
☐ Transgender – Male to Female
☐ Non-Binary
☐ 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: ______________________________

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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___

Medical

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

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

Self-catheter (note ability to perform independently and access to 5 days' worth of supplies)			
Wound Care (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 _____