Champlain Valley
Family Center

Champlain Valley Family Center Recovery Campus
516 Norrisville Rd. Schuyler Falls, NY 12985
Office (518)643-0148 Fax (518)643-2456
www.cvfamilycenter.org

To Start the Referral Process:

Please provide the following information and this completed form by faxing to the fax number above, or call Tracy Turek at the office number above or email at **tturek@cvfamilycenter.org**: **Biopsychosocial assessment, ANY medical information available to include PPD, bloodwork, most recent physical assessment, medications, and recent urine drug screens.** ***If you do not have this available, **still fill out this form** to the best of your ability, fax this form, and call to get the referral process started. Not having this information does not prevent admission to CVFC Recovery Campus***

Admission Date Requested: _____

First Name: _____ **M.I.**___ **Last:** _____ **Sex:** ____ **Age:** ____

Date of Birth: _____ **Soc Sec #:** _____ **County of Residence:** _____

Phone #:_____ **Address:**_____

Referred by: _____ **Phone #:** _____ **Extension:** _____

Email: _____ **Organization:** _____

Financial Info

Medicaid CIN #: _____ **Managed Care?: Y__ N __ Insurance Provider:** _____

Insurance Member ID #: _____ **Temporary Assistance?: Y__ N__**

County?: _____**Is There SSI?** _____ **Disability?** _____ **Private Pay?** _____

Clinical Information

SUD Diagnosis:

_____

_____

SUD Treatment History:

_____

_____

MAT History:

Last Use Date and Substances Used:

Does the individual want to be in treatment? Y__ N__

Psychiatric History

Do they have an AOT? Y___ N___

MH Diagnosis:

Psychiatric Hospitalization History:

Suicide Ideations or Attempts History:

Psychiatric Medication:

*****If patient has had suicide attempt or active psychiatric symptoms, please provide as much of a report as possible on the details of their psychiatric status*****

Medical History

Current Medical Issues:

Allergies:

Food Allergies/Dietary Restrictions:

Previous Major Medical Issues:

Current Physical Health Medications:

Legal Status

Pending Charges and Court They Are In:

_____

Previous Charges:

_____

Probation/Parole/Drug Court and Contact Info:

_____

Is there a court mandate letter? Y__ N __

Registered Sex Offender? Y__ N__

Any Orders of Protection? Y__ N__ If so please provide copy of the OOP or have at time of admission.

Is there a recommendation the current treatment provider has for length of stay? _____

Does the referring provider's treatment team have a recommendation for aftercare? _____

_____

Priority Admission Information

Is the patient an IV Substance user? Y__ N __

Is the patient Pregnant? Y__ N__

Does the patient have children in foster care, or are they at risk of going into foster care? Y__ N __

Is the patient being released from incarceration? Y__ N __

Signature/Title of Referral Source: _____

Date: _____

Phone screening completed with referral on: _____
Date

For Office Use Only

Deductible Amount if applicable? _____ Deductible met? _____ Copay? _____

Employed? Y__ N___ Annual Income? _____ Dependents? _____

(Inform that sliding fee is available if not approved for stay with insurance, congregate care, or SNAP and that financial agreement will be made and signed prior to admission)