victory programs

OPENING DOORS TO HOPE, HEALTH AND HOUSING

STANDARDIZED CLIENT REFERRAL FORM FOR VICTORY PROGRAMS RECOVERY HOMES

(Victory House, New Victories ,Shepherd House, New Joelyn's Home, Women's HOPE COE)

For New Victories and Victory House fax referrals to: (617) 522-1280

For Women's Hope COE fax to: (617) 445-0709

For Shepherd House and New Joelyn's Home fax to: (617) 456-1217

Instructions: Answer all questions. Circle **Y** for yes or **N** for no. For residential referrals, always call first to check for bed availability prior to faxing client information. Fax this Referral Form along with the Psychosocial Assessment, BSAS TB Screening Assessment and History and Physical.

TODAY'S DATE:
REFERRING AGENCY CONTACT PERSON:
CONTACT PHONE #:
HAS CLIENT BEEN ADMITTED TO THIS PROGRAM BEFORE? Y N IF YES, WHEN?

CLIENT INFORMATION

CLIENT LEGAL NAME:
DOB: / / SSN# - -
INSURANCE PROVIDER:
INSURANCE POLICY NUMBER:
PRIMARY LANGUAGE, IF OTHER THAN ENGLISH: RACE/ETHNICITY:
WHAT IS SOURCE OF INCOME?
MASSACHUSETTS RESIDENT? Y N VETERAN? Y N
HOUSING STATUS: ___ CHRONIC HOMELESS ___ NEARLY HOMELESS ___PERMANENT RESIDENCE
LAST PERMANENT ADDRESS:
CHILDREN: AGES: DOES CLIENT HAVE CUSTODY? Y N
IS CLIENT PREGNANT? Y N
DOES CLIENT HAVE PICTURE ID OR MASSHEALTH CARD? Y N IF YES, WHAT?
DOES CLIENT HAVE LEGAL ACTION PENDING? Y N DOES CLIENT HAVE OUTSTANDING WARRANT? Y N
IF YES, WHAT IS ORIGINAL CHARGE(S)?
WHAT IS CURRENT CHARGE?

CLIENT SUBSTANCE USE HISTORY - LIST IN ORDER OF PRIORITY/DRUG OF CHOICE

DRUG	AGE FIRST USE	LAST USE	FREQUENCY OF USE	AMOUNT USED	METHOD OF USE

SCHEDULED APPOINTMENTS (E.G., COURT, DCF, DOCTOR, ETC.)

TYPE APPOINTMENT	DATE/TIME	LOCATION

MEDICAL CONTACTS

	NAME	CITY/TOWN	LAST CONTACT
PRIMARY CARE			
THERAPIST			
PSYCHIATRIST			

MEDICAL HISTORY

HAS CLIENT STOPPED TAKING ANY MEDICATIONS IN PAST SIX MONTHS? Y N
IF YES, WHAT?
DOES CLIENT HAVE ANY ACUTE MEDICAL OR DENTAL TX NEEDS? Y N
IF YES, WHAT?
DOES CLIENT HAVE DISABILITIES? Y N
IF YES, LIST SPECIAL ACCOMMODATIONS NEEDED:
IS CLIENT ON METHADONE/SUBOXONE/VIVITROL? Y N *IF YES, INCLUDE IN LIST OF PRESCRIPTION MEDICATIONS BELOW

MEDICATIONS: LIST ALL MEDS CLIENT IS TAKING AND WILL BE DISCHARGED ON. USE ADDITIONAL PAPER AS NEEDED.

*PRESCRIPTION MEDICATIONS	DOSE/FREQUENCY	REFILLS? Y/N	IF NO, # DAYS LEFT	PRESCRIBER

OVER THE COUNTER MEDS	DOSE/FREQUENCY	REASON

DOES CLIENT HAVE HISTORY OF ANY OF THE FOLLOWING? IF YES, SEE ATTACHED PSYCHOSOCIAL ASSESSMENT FOR MORE INFORMATION

MENTAL HEALTH DIAGNOSIS?	Y	N	TRAUMA?	Y	N
PREVIOUS PSYCH HOSPITALIZATION(S)?	Y	N	HARM TO SELF OR OTHERS?	Y	N
PSYCHOSIS?	Y	N	EATING DISORDER?	Y	N
SUICIDAL IDEATION?	Y	N	HOMICIDAL IDEATION?	Y	N

WAS CLIENT ACCEPTED TO PROGRAM? Y N

IF NO, REASON:

STAFF SIGNATURE _____ **DATE** _____

FAX THIS REFERRAL FORM AND THE CLIENT'S PSYCHOSOCIAL ASSESSMENT, BSAS TB SCREENING ASSESSMENT, HISTORY & PHYSICAL. ADDITIONALLY, MEDICAL RECORDS MAY BE REQUESTED IN ORDER TO PROCESS THIS APPLICATION.