Referral Form for Men's Residential Treatment

Name: ____________________________ Date of Birth: _______________

Physical Address: ____

Mailing Address: ____

Primary Phone Number: (______)________-______________________

Secondary Phone Number: (______)________-______________________

How were you referred to the Highland Recovery Center?

____

____

Marital Status: ○ Single ○Married ○ Divorced ○ Partnered

Employment Status: ____

Substance Use History (please check all that apply):

○ Alcohol ○ Marijuana ○ Methamphetamine ○ Heroin ○ Cocaine/Crack ○ Hallucinogenics
○ Benzodiazepines ○ Opiates ○ Other ________________________________ ○ IV Drug Use

Please indicate last date of use and amount used for above identified substances**:**

____

____

Significant Medical History:

○ Seizure Disorder ○ Hepatitis C ○ Tuberculosis ○ Diabetes ○ Traumatic Brain Injury
○ Other that may require 24/7 medical care.

*Note: These issues do not mean you will be disqualified from entrance into the program.

Please note any other significant medical conditions:

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____

Nicotine use: ○ Non-user ○Periodic user ○ Daily user

Current Medication:

____

____

____

History of Treatment for Mental Health/Substance Use and any know Diagnosis:

○ Inpatient Detoxification ○ Inpatient Mental Health ○ Outpatient Substance Use
○ Outpatient Mental Health ○ Residential Substance Use

Please explain above identified treatment (Where and When)**:**

____
____
____

Current/Pending/Past legal History (If Applicable):

____
____
____
____

Have you participated in a Treatment Court program? ○ Yes ○ No
If yes, please explain the outcome:

____
____

Insurance (If uninsured please note): ____

Primary Care Physician Contact Information:

Name: ________________________________ Phone Number: (______) ________-______________

Emergency Contact Information:

Name: ________________________________ Relationship: ____________________________

Address: ____

Phone Number: (______) ________-______________

Probation/Parole Officer Contact information (If Applicable):

Name: ______________________________ County:_______________________________________

Phone Number: (____) ________-______________ Fax Number: (____) ________-________________

Attorney Contact Information (If Applicable):

Name:_________________________________ Law Firm:______________________________________

Phone Number: (____)________-______________ Fax Number: (____)________-______________

By signing below you attest that the information you have provided in this referral form is accurate to the best of your knowledge. Your signature below and on the attached Releases of Information (ROI), acknowledges that the Highland Recovery Center (HRC) may contact you, your referral source, and any relevant legal/treatment entities involved in your admission process, for the purpose of obtaining more information pertaining to your current status and eligibility for admission, as further delineated by the accompanying ROI. Furthermore, this will serve to relay any relevant information regarding the nature of the program, and/or your date of admission should you be placed on the program's waiting list.

Printed Full Name: ____

Signature: ____ Date:______________

Attached to this referral form you will find two blank Releases of Information (ROI) for Highland Rivers Health CSB to communicate with any relevant parties involved in your possible admission and treatment. Releases of Information may be rescinded at any time by the applicant.

Please return this completed referral form to The Highland Recovery Center via mail, email or fax to the contacts listed below:

Address: The Highland Recovery Center
Attn: Justin Carson
323 Roland Road
Jasper, GA 30143
Fax: 706-253-1113

Email: justincarson@highlandrivers.org

For further Information please contact:

Justin Carson, MS, LPC, NCC
Residential Program Manager
Highland Rivers Health
The Highland Recovery Center
Phone: 706-253-1169 Ext: 5314