RESIDENTIAL RECOVERY PROGRAM REFERRAL FORM

For Residential Use Only

Date Received: _____

Reviewed By: _____

Name

_____

Date

☐ Admit ☐ Wait ☐ Referred

Referring Agent: _____

Agency Represented: _____

Referring Agency Phone #: _____

Guest Name: _____

DOB: ____/____/_____ **Age:** _____ **SS#:** _____-____-_____ **Gender: M / F**

Current Address: _____ **Phone #:** _____

Reason why the individual is requesting services:

_____

_____**Brief description of where client was staying prior to coming to hospital/jail, if they are able to return there, and what might be needed to allow them to return**

_____

_____

_____

Does the individual have any family/friends (anywhere) that they may be able to stay with? What assistance would be needed in order to be able to stay there?

Are there any other options that can be/have been explored before the client is referred to shelter:

_____

_____

Support Services Needed: _____

Physical Limitations: _____

Behavior concerns: _____

Requested amount of time in the program:

Circle One: Uninsured / Medicare / Medicaid

☐ **ATTACH DISCHARGE INSTRUCTION RECORD OR OTHER RELEVANT ASSESSMENT**
☐ **ATTACH H&P or DOCUMENTATION OF A PHYSICAL EXAM**
☐ **ATTACH MEDICATION LIST/DOCTOR'S ORDER FOR ALL MEDICATIONS**

I have reviewed this application and agree with its content. I would like to be considered for placement in the residential recovery program

_____ _____

Guest Signature Date

HISTORY AND PHYSICAL REPORT MAY BE SUBSTITUTED FOR THIS FORM

Micah Ecumenical Ministries

MEDICAL EXAMINATION

This section to be completed by family or staff

Type of Exam: ☐ General Medical ☐ Internist ☐ Surgical ☐ Other

Patient Name:		Address:
DOB	SSN#	

Duration and Work Limitations:

Can Patient:	**Yes**	**No**	**With Assistance**
Evacuate in an Emergency			
Self-medicate			

MEDICAL HISTORY (Mark appropriate symptom)

YES	**NO**		If Yes, please explain
		Hospitalization/Surgery	
		Heart Disease, chest pain, high blood pressure	
		Lung Disease, short of breath, habitual cough	
		Gastro-intestinal disorder	
		Kidney, liver or bladder disease	
		Genital/urinary tract disorder	
		Cancer	
		Poor vision or hard of hearing	
		Seizures, fainting, headache	
		Stroke, paralysis	
		Psychiatric, nervous system disorder	
		Back pain, arthritis	
		Diabetes, thyroid disorder	
		Substance Abuse	
		Weight loss (10+ lbs in 3 mos)	
		Sexually transmitted disease	
		Medication reaction	
		Sensitivity to drugs or chemicals	
		Allergies, chronic conditions	
		Tuberculosis	
		Other communicable disease	

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Distant Vision	Right	Left
W/O glasses		
W/ glasses		

Near Vision	Right	Left
W/O glasses		
With glasses		

Height:	Weight:	Blood Pressure:
Urinalysis:	Albumin:	Sugar:

Normal	Abnormal	Phys. Exam
		Eyes
		Ears, Nose, Throat
		Mouth, Teeth
		Neck, Thyroid
		Lymphatic system
		Breasts
		Lung, Chest
		Heart
		Abdomen, Hernia
		Genitalia, pelvic
		Genito-urinary
		Ano-Rectal
		Limbs, Joints, Spine
		Edema, Vericose veins
		Neurological Gait
		Pschiatric
		General Appearance

FUNCTIONAL & ENVIRONMENTAL LIMITATIONS

OTHER CONDITIONS: _____

_____

_____

___Acute ___Chronic ___Stable ____Improving _____Transient _____Permanent ____Progressive

COMMENTS/RECOMMENDATIONS (please include need for further studies or immunizations): _____

_____

_____

Physician Signature: _____ **Specialty:** _____

PRINT PHYSICIAN NAME: _____ **Date of Exam:** _____