

Instructions for Referral to Residential Treatment

1. **Initial Contact:** Call the Intake Coordinator for a preliminary discussion about bed openings, admission requirements, patient needs, NWITC policies and other questions.

2. **Referrals:** All referrals will need to have the following prior to placement:
 - A. **Drug and Alcohol Assessment** with recommendation for In-patient treatment. See notes below.
 - If Alternative Benefit Plan, both the Target (pages 1-7) and the DBHR Adult Assessment is required.
 - If contract type is Family Medical, GA-U, GA-X, SSI, or TANF, The Target pages are not required but a drug and alcohol assessment is still needed.
 - If contract is Purchase Order, Indian Health Services or another type, a current drug and alcohol assessment is needed.

 - B. **Payment method established.** Medical coupon, Insurance card, purchase order.

 - C. **Pre-treatment Physical** to include lab work and current TB test results.

 - D. **Signed Release of Information** in accordance with 42 CFR and federal HIPPA.

3. **Medical Requirements:** A pre-treatment physical is to be completed by a health care provider within the past 90 days (preferably using the NWITC forms) and must include the following:
 - A. History and Physical report.
 - B. CBC = Complete Blood Count.
 - C. CMP = Comprehensive Metabolic Panel.
 - D. TB test current within the last 12 months.
(If TB skin test is positive, a chest x-ray report is required.)
 - E. A hepatitis screen is advised and may be required if LFT's are elevated or patient has used intravenous drugs.
 - F. Check for pregnancy (if female of child bearing potential).
 - G. When cardiopulmonary disorders are present, additional tests may be necessary, including, but not limited to, an EKG and chest x-ray.
 - H. If the patient has had mental health issues, such as clinical depression, suicidal ideation or any type of psychological problem, a current and complete mental health evaluation may also be required, along with stabilization or medication if evaluation recommends.
 - I. The treatment center's nurse will review all medical information. There may be additional follow up requested. However, if nothing further is required, the intake coordinator will contact you for an admission date for your client.

*** Confidential ***

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Northwest Indian Treatment Center
PO Box 477, Elma, Washington 98541
Phone 360-482-2674 Fax 360-482-1413

Residential Program Consent for Release of Confidential Information
Patient's Referring Alcohol and Drug Program

I, _____
(Name of Patient)

hereby authorize the exchange of information between Northwest Indian Treatment Center and

(Name and Title of Person or Agency Exchanging Information)

(Address, including zip code) *Telephone Number, including area code)*

Information to be released and/or exchanged

(Mark each item Yes or No)

- | | |
|---|--|
| <p><u>YES</u> Identifying Information</p> <p><u>YES</u> Admission Registration</p> <p><u>YES</u> Diagnosis, Date of Service</p> <p><u>YES</u> General progress / Condition</p> <p><u>YES</u> History and Physical</p> <p><u>YES</u> Laboratory Reports</p> <p><u>YES</u> Doctor's Orders</p> <p><u>YES</u> Consultations</p> <p><u>YES</u> Treatment Plan Summary</p> | <p><u>YES</u> Assessment Summary</p> <p><u>NO</u> Academic Information</p> <p><u>YES</u> Discharge Summary</p> <p><u>YES</u> Medical Discharge Summary</p> <p><u>NO</u> Continuing Care Participation</p> <p><u>NO</u> Family Questionnaire</p> <p><u>YES</u> Family Program Information</p> <p>_____ Other (<i>specify</i>) _____</p> |
|---|--|

The purpose or need for the exchange and disclosure of this information is to:

- Facilitate Treatment; Summarize Treatment; Coordinate Continuing Care
- Other (*please state purpose clearly*): evaluate patient's needs, provide referring programs with progress reports, plans for continuing care and consent for follow-up questions regarding recovery needs.

I understand that this consent is subject to revocation at any time except to the extent that action has been taken in the reliance thereon and, unless earlier revoked, shall expire 160 days from the date of signature, or as otherwise specified:

Date Signature of Witness Date

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Information to be released and/or exchanged

(Mark each item Yes or No)

- | | |
|------------------------------------|-------------------------------------|
| _____ Identifying Information | _____ Assessment Summary |
| _____ Admission Registration | _____ Academic Information |
| _____ Diagnosis, Date of Service | _____ Discharge Summary |
| _____ General progress / Condition | _____ Medical Discharge Summary |
| _____ History and Physical | _____ Continuing Care Participation |
| _____ Laboratory Reports | _____ Family Questionnaire |
| _____ Doctor's Orders | _____ Family Program Information |
| _____ Consultations | _____ Other (specify) _____ |
| _____ Treatment Plan Summary | |

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Signature of Patient

Date

Signature of Witness

Date

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HISTORY & PHYSICAL

(This form is to be completed by a Physician, NP, PA, or RN)

Current medications	Dosing	Date began	To be taken until	To treat

Drug sensitivities or allergies	Type of reaction	Date of reaction, if known

Other types of allergies	Type of reaction	Date of reaction, if known

PAST MEDICAL HISTORY

IMMUNIZATIONS: Specify the dates (if known) of patient's last:			
DPT	Td	Pneumovax	Influenza vaccine

PPD			
Date placed	Date read	Reaction	mm

Surgical procedures	Location	Date

Hospitalizations (reason)	Location	Date

Fractures & other injuries	Cause	Date

MEDICAL ILLNESSES					
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Gallbladder Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> STDs	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> None of the Above	
<input type="checkbox"/> Others					

Patient Name: _____ **DOB:** _____ **Page 1 of 3**

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REVIEW OF SYSTEMS

WITHDRAWAL SYMPTOMS (for each positive response, specify how recently)							
<input type="checkbox"/> Shakes / tremors		<input type="checkbox"/> Sweats		<input type="checkbox"/> Palpitations		<input type="checkbox"/> Cravings	
<input type="checkbox"/> Seizures/convulsions		<input type="checkbox"/> Hangovers		<input type="checkbox"/> Insomnia		<input type="checkbox"/> Blackouts	
<input type="checkbox"/> DTs / hallucinations		<input type="checkbox"/> Morning nausea		<input type="checkbox"/> Depressed mood		<input type="checkbox"/> Muscle cramps / pain	
<input type="checkbox"/> Abdominal pain		<input type="checkbox"/> NONE					
GENERAL							
<input type="checkbox"/> No symptoms				<input type="checkbox"/> Weight change			
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Dizziness				
SEXUAL PREFERENCE							
<input type="checkbox"/> Heterosexual		<input type="checkbox"/> Homosexual		<input type="checkbox"/> Bisexual			
INTEGUMENT							
<input type="checkbox"/> No symptoms							
<input type="checkbox"/> Rash		<input type="checkbox"/> Hair loss		<input type="checkbox"/> Nail changes			
OPHTHALMIC							
<input type="checkbox"/> No symptoms				<input type="checkbox"/> Loss of vision			
<input type="checkbox"/> Diplopia	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Corrective lenses				
ENT							
<input type="checkbox"/> No symptoms			<input type="checkbox"/> Ear pain		<input type="checkbox"/> Hearing loss		
<input type="checkbox"/> Sinus pain	<input type="checkbox"/> Epistaxis	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Dysphagia				
CARDIOVASCULAR / PULMONARY							
<input type="checkbox"/> No symptoms				<input type="checkbox"/> Chest pain		<input type="checkbox"/> Palpitations	
<input type="checkbox"/> Peripheral edema	<input type="checkbox"/> Cough	<input type="checkbox"/> Sputum	<input type="checkbox"/> Hemoptysis				
<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Orthopnea	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Bruising easily				
GASTROINTESTINAL							
<input type="checkbox"/> No symptoms				<input type="checkbox"/> Anorexia		<input type="checkbox"/> Nausea	
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Abdominal pain				
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Reflux	<input type="checkbox"/> Melena	<input type="checkbox"/> Hematochezia				
MUSCULOSKELETAL							
<input type="checkbox"/> No symptoms							
<input type="checkbox"/> Weakness		<input type="checkbox"/> Paralysis		<input type="checkbox"/> Joint pain		<input type="checkbox"/> Back pain	
GENITOURINARY							
<input type="checkbox"/> No symptoms							
<input type="checkbox"/> Frequency		<input type="checkbox"/> Urgency		<input type="checkbox"/> Dysuria		<input type="checkbox"/> Hesitation	
<input type="checkbox"/> Polyuria		<input type="checkbox"/> Nocturia		<input type="checkbox"/> Hematuria		<input type="checkbox"/> Urethral discharge	
<input type="checkbox"/> Impotence				<input type="checkbox"/> Testicular pain			
MALES:		<input type="checkbox"/> Metrorrhagia		<input type="checkbox"/> Dyspareunia		<input type="checkbox"/> Possibly pregnant	
<input type="checkbox"/> Menorrhagia						<input type="checkbox"/> LMP:	
<input type="checkbox"/> Gravida:	<input type="checkbox"/> Para:	<input type="checkbox"/> Ab:	<input type="checkbox"/> Stillbirths:	<input type="checkbox"/> Living children:			
NEUROLOGICAL							
<input type="checkbox"/> No symptoms		<input type="checkbox"/> Paralysis		<input type="checkbox"/> Speech disturbance		<input type="checkbox"/> Headaches	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Anesthesias	<input type="checkbox"/> Paresthesias	<input type="checkbox"/> Gait abnormalities				
PSYCHIATRIC							
<input type="checkbox"/> No symptoms							
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Depressed mood		<input type="checkbox"/> Tearfulness		<input type="checkbox"/> Suicidal thoughts	

Patient Name: _____

DOB: _____

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PHYSICAL EXAMINATION

Temperature	Pulse	Reg. or Irreg.	Blood Pressure	Respirations
Height	Weight	<input type="checkbox"/> Alert;	Oriented to	<input type="checkbox"/> person <input type="checkbox"/> place <input type="checkbox"/> time
GENERAL APPEARANCE, BEHAVIOR & MOOD				
<input type="checkbox"/> Well groomed	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Smells of EtOH	<input type="checkbox"/> Agitated	
<input type="checkbox"/> Apathetic	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Depressed	<input type="checkbox"/> Other observations	
SKIN				
<input type="checkbox"/> Within normal limits				
<input type="checkbox"/> Rashes	<input type="checkbox"/> Lesions	<input type="checkbox"/> Scars	<input type="checkbox"/> Needle tracks	<input type="checkbox"/> Signs of recent trauma
EYES				
Pupils	<input type="checkbox"/> Equal	<input type="checkbox"/> Round	<input type="checkbox"/> Reactive to light	
<input type="checkbox"/> EOMs intact	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Icteric	<input type="checkbox"/> Conjunctivitis
EARS				
<input type="checkbox"/> Within normal limits	<input type="checkbox"/> TMs inflamed	<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Hearing aids
NOSE				
<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Rhinorrhea	<input type="checkbox"/> Polyps	<input type="checkbox"/> Nasal obstruction	
MOUTH / THROAT / NECK				
<input type="checkbox"/> Within normal limits				
<input type="checkbox"/> Dentures	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Erythema	<input type="checkbox"/> Exudate	<input type="checkbox"/> Lymphadenopathy
CARDIOVASCULAR				
<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Murmur	<input type="checkbox"/> Gallop	<input type="checkbox"/> JVD
PULMONARY				
<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Wheezes	<input type="checkbox"/> Crackles	<input type="checkbox"/> Decreased tidal volume	
ABDOMEN				
<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Protuberant	<input type="checkbox"/> Abnormal bowel sounds	<input type="checkbox"/> Tender	<input type="checkbox"/> Masses <input type="checkbox"/> Rigid
EXTREMITIES				
<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Deformity	<input type="checkbox"/> Edema	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Weakness <input type="checkbox"/> Abnormal reflexes

REQUIRED FOR ALL PATIENTS

- Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) Reports
- TB test results within last 12 months
- Chest X-ray if TB skin test is positive
- Urine HCG for all females of childbearing potential
- Hepatitis screen for IV drug users, or if liver enzymes are elevated
- 12 lead EKG with reading by internist or cardiologist, if cardiopulmonary disorders are present

Are there any problems which would prohibit participation in a chemical dependency program? Yes ___ No ___

Explanation by medical practitioner is required for all abnormal lab results.

Problems identified	Plan

Signature of Examiner: _____ Print Name: _____ Date: _____
 Patient Name: _____ DOB: _____ Page 3 of 3

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Medication Payment Agreement

I / we, _____
Please print name(s)

_____ Address _____ Phone _____

agree to pay for any medications, medical appointments or emergent care that may become necessary for _____, _____,
Patient's Name Date of birth

during his/her stay in residential treatment at Northwest Indian Treatment Center.

Signature of responsible party

Printed name of responsible party

Title of responsible party

Date

Signature of second responsible party

Printed name of second responsible party

Title of second responsible party

Date

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Residential Program
What to Bring to Treatment
(Items other than those listed or more than listed
will be placed in storage or returned with driver.)

Clothing

- Limit 10 slacks / pants
- Limit 10 shirts / blouses (none that are short, tight, tank tops or low necklines)
- Limit 10 pair socks
- Limit 10 pair underwear
- Limit 1 or 2 pair walking shoes, 1 pair house slippers, 1 pair flip-flops for shower
- Limit 5 pair pajamas or gowns, 1 robe (non-revealing)
- Limit 3 warm sweatshirts or sweaters
- Limit 1 heavy coat 1 light jacket
- Shorts (just above the knee)

Personal Items

(hygiene items must be alcohol free)

- phone card
- toothbrush, toothpaste, floss
- brush, comb, hair gel
- package of 20 razors
- shampoo, conditioner, soap
- 1 deodorant
- 1 lotion
- 1 package of Q-tips
- nail file, clippers, tweezers
- (ladies) sanitary napkins
- 3 containers of cosmetics
- stationery, stamps, 2 pens, 2 notebooks
- 5 – 6 photographs
- 1 favorite blanket, 1 pillow (if desired)
- Tampons must be cardboard applicator
- Cigarettes or chewing tobacco

Food Items

- Pop : 2 / 12 packs
- Top Ramen or cup of noodle: 1 case each
- Aquafina flavored water: 24 limit
- Jerky
- Pepperoni
- Corn nuts
- Popcorn: no kettle corn, 12 packages
- 100% juice: individual - 12 limit
- Nuts : no shells, no honey roasted
- Coffee Powdered Creamer: 64 oz
- Coffee: instant, 2 containers – flavored or regular

Laundry soap is provided

Limit items brought to no more than two suitcases, bags or boxes.

Please note that fragrances (perfumes, colognes, body sprays, etc.) are not allowed in any form.

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