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

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** from an external facility with recommendation for In-patient treatment for ASAM level 111.1, 111.3 or 111.5. See notes below.
   - If Medicaid, both the Target (pages 1-7) and the DBHR Adult Drug & Alcohol Assessment is required.
   - If contract is Purchase Order, Indian Health Services or another type, a current drug and alcohol assessment is needed.

   B. **Payment method established.** Medicaid for Native clients (BHO opt-out), Insurance card, Purchase order.
   C. **Pre-treatment Physical** to include lab work.
   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. A hepatitis screen is advised and may be required if LFT's are elevated or patient has used intravenous drugs.
   E. Check for pregnancy (if female of child bearing potential).
   F. When cardiopulmonary disorders are present, additional tests may be necessary, including, but not limited to, an EKG and chest x-ray.
   G. 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.
   H. 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.

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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***)

YES	Identifying Information	**YES**	Assessment Summary
YES	Admission Registration	**NO**	Academic Information
YES	Diagnosis, Date of Service	**YES**	Discharge Summary
YES	General progress / Condition	**YES**	Medical Discharge Summary
YES	History and Physical	**NO**	Continuing Care Participation
YES	Laboratory Reports	**NO**	Family Questionnaire
YES	Doctor's Orders	**YES**	Family Program Information
YES	Consultations	______	Other (*specify*) ____________
YES	Treatment Plan Summary		

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:

______________________________ ______________________________
Signature of Patient Date Signature of Witness Date

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Residential Program Consent for Release of Confidential Information

Patient's Health Clinic

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***)

YES	Identifying Information	**NO**	Assessment Summary
No	Admission Registration	**NO**	Academic Information
YES	Diagnosis, Date of Service	**No**	Discharge Summary
No	General progress / Condition	**NO**	Medical Discharge Summary
YES	History and Physical	**YES**	Continuing Care Participation
YES	Laboratory Reports	**NO**	Family Questionnaire
YES	Doctor's Orders	**NO**	Family Program Information
YES	Consultations	______	Other (*specify*) ____________
NO	Treatment Plan Summary		

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.

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______	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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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					
☐ Hypertension	☐ Heart Disease	☐ Anemia	☐ Asthma	☐ COPD	☐ Tuberculosis
☐ Cancer	☐ Diabetes	☐ Thyroid Disease	☐ Ulcers	☐ Liver Disease	☐ Gallbladder Disease
☐ Arthritis	☐ Kidney Disease	☐ STDs	☐ Mental Illness	☐ None of the Above	
☐ Others					

Patient Name: ______________________ **DOB:** ______________________

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REVIEW OF SYSTEMS

WITHDRAWAL SYMPTOMS (for each positive response, specify how recently)							
☐ Shakes / tremors		☐ Sweats		☐ Palpitations		☐ Cravings	
☐ Seizures/convulsions		☐ Hangovers		☐ Insomnia		☐ Blackouts	
☐ DTs / hallucinations		☐ Morning nausea		☐ Depressed mood		☐ Muscle cramps / pain	
☐ Abdominal pain		☐ NONE					

GENERAL			
☐ No symptoms			☐ Weight change
☐ Fatigue	☐ Fever	☐ Chills	☐ Dizziness
SEXUAL PREFERENCE			
☐ Heterosexual	☐ Homosexual	☐ Bisexual	
INTEGUMENT			
☐ No symptoms			
☐ Rash	☐ Hair loss	☐ Nail changes	
OPHTHALMIC			
☐ No symptoms			☐ Loss of vision
☐ Diplopia	☐ Eye pain	☐ Blurry vision	☐ Corrective lenses
ENT			
☐ No symptoms		☐ Ear pain	☐ Hearing loss
☐ Sinus pain	☐ Epistaxis	☐ Hoarseness	☐ Dysphagia
CARDIOVASCULAR / PULMONARY			
☐ No symptoms		☐ Chest pain	☐ Palpitations
☐ Peripheral edema	☐ Cough	☐ Sputum	☐ Hemoptysis
☐ Dyspnea	☐ Orthopnea	☐ Varicose veins	☐ Bruising easily
GASTROINTESTINAL			
☐ No symptoms		☐ Anorexia	☐ Nausea
☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Abdominal pain
☐ Jaundice	☐ Reflux	☐ Melena	☐ Hematochezia
MUSCULOSKELETAL			
☐ No symptoms			
☐ Weakness	☐ Paralysis	☐ Joint pain	☐ Back pain

GENITOURINARY					
☐ No symptoms					
☐ Frequency		☐ Urgency	☐ Dysuria		☐ Hesitation
☐ Polyuria		☐ Nocturia	☐ Hematuria		☐ Urethral discharge
MALES:			☐ Impotence		☐ Testicular pain
FEMALES:	☐ Menorrhagia	☐ Metrorrhagia	☐ Dyspareunia	☐ Possibly pregnant	☐ LMP:
☐ Gravida:	☐ Para:	☐ Ab:	☐ Stillbirths:	☐ Living children:	

NEUROLOGICAL			
☐ No symptoms	☐ Paralysis	☐ Speech disturbance	☐ Headaches
☐ Seizures	☐ Anesthesias	☐ Paresthesias	☐ Gait abnormalities
PSYCHIATRIC			
☐ No symptoms			
☐ Anxiety	☐ Depressed mood	☐ Tearfulness	☐ Suicidal thoughts

Patient Name: ______________________ **DOB:** ______________________

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PHYSICAL EXAMINATION

Temperature	Pulse Reg. or Irreg.	Blood Pressure	Respirations
Height	Weight	☐ Alert; Oriented to ☐ person ☐ place ☐ time	

GENERAL APPEARANCE, BEHAVIOR & MOOD				
☐ Well groomed	☐ Cooperative	☐ Smells of EtOH	☐ Agitated	
☐ Apathetic	☐ Withdrawn	☐ Depressed	☐ Other observations	
SKIN				
☐ Within normal limits				
☐ Rashes	☐ Lesions	☐ Scars	☐ Needle tracks	☐ Signs of recent trauma
EYES				
Pupils ☐ Equal ☐ Round ☐ Reactive to light				
☐ EOMs intact	☐ Glasses	☐ Contact lenses	☐ Icteric	☐ Conjunctivitis
EARS				
☐ Within normal limits	☐ TMs inflamed	☐ Ear discharge	☐ Hearing loss	☐ Hearing aids
NOSE				
☐ Within normal limits	☐ Rhinorrhea	☐ Polyps	☐ Nasal obstruction	
MOUTH / THROAT / NECK				
☐ Within normal limits				
☐ Dentures	☐ Hoarseness	☐ Erythema	☐ Exudate	☐ Lymphadenopathy
CARDIOVASCULAR				
☐ Within normal limits	☐ Arrhythmia	☐ Murmur	☐ Gallop	☐ JVD
PULMONARY				
☐ Within normal limits	☐ Wheezes	☐ Crackles	☐ Decreased tidal volume	

ABDOMEN					
☐ Within normal limits	☐ Protuberant	☐ Abnormal bowel sounds	☐ Tender	☐ Masses	☐ Rigid
EXTREMITIES					
☐ Within normal limits	☐ Deformity	☐ Edema	☐ Prosthesis	☐ Weakness	☐ Abnormal reflexes

REQUIRED FOR ALL PATIENTS

☐ Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) Reports
☐ 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

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

Problems identified	Plan

Signature of Examiner: ______________________ **Print Name:** ______________________ **Date:** __________

Patient Name: ______________________ **DOB:** ______________________

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

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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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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

Laundry soap is **provided**

Food Items

- ☐ Pop (Caffeine Free, single servings)
- ☐ Aquafina flavored water: 24 limit
- ☐ 100% juice: individual - 12 limit
- ☐ Hot Chocolate (single servings)
- ☐ Top Raman or cup of noodle: limit 24
- ☐ Popcorn (no kettle corn)
- ☐ Pretzels-regular
- ☐ Shelled Nuts (no shell)
- ☐ Jerky
- ☐ Pepperoni sticks / jerky
- ☐ Corn nuts
- ☐ Peanut butter /cheese crackers
- ☐ Crackers-no graham or Teddy grahams
- ☐ Trail mix -no chocolate or candy in the mix

***Electronics, Fitbit, i-watch and similar devices are *not allowed*.**
***Please note that fragrances (perfumes, colognes, body sprays, lotions, etc.) are *not allowed* in any form.**

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

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