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 111.5. See notes below.
     - If Medicaid, both the Target (pages 1-7) and the HCA 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.
   - **E. Re-application questionnaire** for any returning client.

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.**
Consent for Release of Confidential Information  
Patient’s Referring Alcohol and Drug Program

I, ____________________________________________, hereby authorize the exchange of verbal and written information in the area of physical health, mental health and substance abuse treatment services between Northwest Indian Treatment Center and:

<table>
<thead>
<tr>
<th>Patient’s Referring Agency</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address | City | State | Zip
Code

The information to be released and information exchanged includes (please check information we may release):

- ✔ Identifying Information
- ✔ Admission Registration
- ✔ Diagnosis, Date of Service
- ✔ General Progress, Condition
- ✔ Consultations
- ✔ History and Physical
- ✔ Laboratory Reports
- ✔ Doctors’ Orders
- ✔ Progress Notes
- ✔ Psychiatric Consultation
- ✔ Psychological Evaluation
- ✔ Biopsychosocial Summary
- ✔ Treatment Plan
- ✔ Continuing Care Participation
- ✔ Medical Discharge Summary
- ✔ Discharge Summary

The purpose of the disclosures authorized is to exchange patient information to provide consultation for treatment planning and aftercare.

Mode of delivery may be made by: ☒ phone  ☒ mail  ☒ fax  ☒ email  ☒ on-site

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 C.F.R. Part 2 and the Health Insurance Portability and accountability Act of 1996 HIPPA). I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Otherwise it will remain in effect until 180 days after the above client leaves treatment at Northwest Indian Treatment Center.

Signature of Patient  Date  Signature of Witness  Date

*** Confidential ***

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.
Northwest Indian Treatment Center  
PO Box 477, Elma, Washington 98541  
Phone 360-482-2674  Fax 360-482-1413

Consent for Release of Confidential Information  
Patient’s Health Clinic

I, __________________________________________, hereby authorize the exchange of verbal and written information in the area of physical health, mental health and substance abuse treatment services between Northwest Indian Treatment Center and:

Patient’s Health Clinic | Phone Number | Fax Number

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

The information to be released and information exchanged includes (please check information we may release):

- Identifying Information
- Psychological Evaluation
- Diagnosis, Date of Service
- Continuing Care Participation
- Doctors’ Orders
- Medical Discharge Summary
- Consultations
- History and Physical
- Laboratory Reports
- OTHER:

The purpose of the disclosures authorized in this content is to improve patient care by allowing communication for medical care, medical follow-up care, coordination of care, obtaining medication and pre-admission requirements.

Mode of delivery may be made by: ☑ phone ☑ mail ☑ fax ☑ email ☑ on-site

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 C.F.R. Part 2 and the Health Insurance Portability and accountability Act of 1996 HIPPA). I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Otherwise it will remain in effect until 180 days after the above client leaves treatment at Northwest Indian Treatment Center.

Signature of Patient: ___________________________  Date: ___________________________
Signature of Witness: ___________________________  Date: ___________________________
Consent to Exchange Confidential Information

Admission

I, _____________________________________________, (Patient Name: First, Last)
hereby authorize the exchange of verbal and written information in the area of physical health, mental health and substance abuse treatment services between Northwest Indian Treatment Center and:

To:
(Personal exchanging information to) (Phone Number) (Alternate Phone Number)

The information to be exchanged are identifying information, transportation arrangements and assessment requirements for admission. The purpose for this exchange is to facilitate admission into treatment.

Mode of delivery may be made by: ☑ phone ☑ mail ☑ fax ☑ email ☑ Voicemail / Message

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 C.F.R. Part 2 and the Health Insurance Portability and accountability Act of 1996 HIPPA). I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Otherwise it will remain in effect until 180 days after the above client leaves treatment at Northwest Indian Treatment Center.

Signature of Patient Date
**HISTORY & PHYSICAL**

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

<table>
<thead>
<tr>
<th>Current medications</th>
<th>Dosing</th>
<th>Date began</th>
<th>To be taken until</th>
<th>To treat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug sensitivities or allergies</th>
<th>Type of reaction</th>
<th>Date of reaction, if known</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other types of allergies</th>
<th>Type of reaction</th>
<th>Date of reaction, if known</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PAST MEDICAL HISTORY**

**IMMUNIZATIONS:** Specify the dates (if known) of patient’s last:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date began</th>
<th>To be taken until</th>
<th>To treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PPD**

Date placed | Date read | Reaction | mm
---|---|---|---|

<table>
<thead>
<tr>
<th>Surgical procedures</th>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations (reason)</th>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fractures &amp; other injuries</th>
<th>Cause</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:** _____________ **Page 1 of 3**
## REVIEW OF SYSTEMS

<table>
<thead>
<tr>
<th>WITHDRAWAL SYMPTOMS (for each positive response, specify how recently)</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Shakes / tremors</td>
</tr>
<tr>
<td>❑ DTs / hallucinations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
<tr>
<td>❑ Fatigue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEXUAL PREFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Heterosexual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTEGUMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
<tr>
<td>❑ Rash</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPHTHALMIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARDIOVASCULAR / PULMONARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GASTROINTESTINAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENITOURINARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
<tr>
<td>❑ Frequency</td>
</tr>
<tr>
<td>❑ Gravida:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PSYCHIATRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No symptoms</td>
</tr>
</tbody>
</table>

---

**Patient Name:** __________________________  **DOB:** __________________________  **Page 2 of 3**

---

**PHYSICAL EXAMINATION**

---

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---

**Confidential**
### 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
- TM inflamed
- Ear discharge
- Hearing loss
- Hearing aids

### NOSE
- Within normal limits
- Rhinorrhea
- Polyp
- 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.

<table>
<thead>
<tr>
<th>Problems identified</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Signature of Examiner:</th>
<th>Print Name:</th>
<th>Date:</th>
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</table>

Patient Name: ___________________________ DOB: __________

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

---

**Confidential**

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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
Admission Questionnaire

NWITC believes that an important aspect of recovery is consistent structure and clear expectations, as well as compassion and warm support.

1. Are you aware of the Northwest Indian Treatment Center rules regarding participation, respectful behavior, and no interaction between genders? Please provide a paragraph describing your commitment to these expectations.

2. If you were discharged in the past for failing to meet these requirements, please describe those behaviors, and your commitment to change.

3. How long were you clean after your last stay? Describe what led to your relapse.

4. Do you have any needs that were not met in your last stay?

5. What is your motivation for returning? Your hope?
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

*Electronic Cigarettes, Electronics, watches, 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.