

Instructions for Referral to Residential Treatment

- 1. Initial Contact:** Northwest Indian Treatment Center is a 45-day minimum treatment program. Please 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 recommending in-patient treatment 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 including a way to pay for medications.** NWITC accepts Washington Medicaid and Tribal purchase orders.

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

 - D. Patient health questionnaire-** NWITC will review to determine if additional medical screening is required. Will need labs if clients Medicaid has a MCO attached.

 - E. Re-application questionnaire** for any returning client.

- 3. Medical Requirements that may be requested include but not limited to:**
 - 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 childbearing 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.

*** 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.

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:

Patient's Referring Agency	Phone Number	Fax Number	
Address	City	State	Zip
Code			

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

- | | |
|---|---|
| <input checked="" type="checkbox"/> Identifying Information | <input checked="" type="checkbox"/> Progress Notes |
| <input checked="" type="checkbox"/> Admission Registration | <input checked="" type="checkbox"/> Psychiatric Consultation |
| <input checked="" type="checkbox"/> Diagnosis, Date of Service | <input checked="" type="checkbox"/> Psychological Evaluation |
| <input checked="" type="checkbox"/> General Progress, Condition | <input checked="" type="checkbox"/> Biopsychosocial Summary |
| <input checked="" type="checkbox"/> Consultations | <input checked="" type="checkbox"/> Treatment Plan |
| <input checked="" type="checkbox"/> History and Physical | <input checked="" type="checkbox"/> Continuing Care Participation |
| <input checked="" type="checkbox"/> Laboratory Reports | <input checked="" type="checkbox"/> Medical Discharge Summary |
| <input checked="" type="checkbox"/> Doctors' Orders | <input checked="" type="checkbox"/> 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** ***

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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	
Address	City	State	Zip
Code			

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

- | | |
|---|---|
| <input checked="" type="checkbox"/> Identifying Information | <input checked="" type="checkbox"/> Medical Discharge Summary |
| <input checked="" type="checkbox"/> Psychological Evaluation | <input checked="" type="checkbox"/> Consultations |
| <input checked="" type="checkbox"/> Diagnosis, Date of Service | <input checked="" type="checkbox"/> History and Physical |
| <input checked="" type="checkbox"/> Continuing Care Participation | <input checked="" type="checkbox"/> Laboratory Reports |
| <input checked="" type="checkbox"/> Doctors' Orders | <input type="checkbox"/> 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
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**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

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PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ D.O.B: ____/____/____
 PRIMARY HEALTH CLINIC: _____ PHONE NUMBER: _____
 TRIBE: _____ GENDER: Male / Female
 COMPLETED BY: _____ TODAYS DATE: ____/____/____

DO NOT LEAVE ANY SECTIONS BLANK

Do you currently take prescribed medications?

Yes or No IF YES, COMPLETE SECTION BELOW

Current medications	Dosage	To treat

Are you on medication assisted treatment (MAT)?

Yes or No IF YES, COMPLETE SECTION BELOW

Suboxone Yes or No

Vivitrol Yes or No Other: _____

Do you have any allergies?

Yes or No IF YES, COMPLETE SECTION BELOW

Allergies	Type of reaction

Have you ever been hospitalized or had surgery?

Yes or No IF YES, COMPLETE SECTION BELOW

Hospitalizations (reason)	Year

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

Patient Name: _____ **D.O.B.** / /

Do you have any mental health diagnosis or ever taken mental health medications?

Yes or **No** IF YES, COMPLETE SECTION BELOW

Mental Health Diagnosis	Mental Health Medications	Year diagnosed

Have you ever been hospitalized for any mental health reason?

Yes or **No** if yes, explain _____

Do you need assistance with activities of daily living?

(dressing, bathing, toileting, eating)

Yes or **No** if yes, explain _____

Do you have any mobility limitations or use any assistive medical equipment? (cane, walker, wheelchair)

Yes or **No** if yes, explain _____

Are you currently being treated for any medical issues?

Yes or **No** if yes, explain _____

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

Patient Name: _____ **D.O.B.** / / _____

Do you have any of the following medical conditions?

Answer all questions Yes or No

Condition	Yes or No	If yes, explain below
Diabetes	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Insulin dependent?
Kidney disease	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Liver disease (hepatitis, cirrhosis, etc.)	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Heart disease	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
History of heart attack	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Chest pain	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
COPD	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Tuberculosis or history of positive TB test	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
History of Stroke	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
High blood pressure	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
History of Seizure	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
History of head injury	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Chronic pain	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Pregnant	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Due date?
Current skin issues (open sores, abscesses, wounds, rash)	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Immune system suppression	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Cold or flu like symptoms	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Fever	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
Have you ever had COVID-19	<input type="checkbox"/> Yes or <input type="checkbox"/> No	When ?
Exposure to anyone with COVID-19 virus within the last 14 days	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
OTHER	<input type="checkbox"/> Yes or <input type="checkbox"/> No	

NOTE: If patient has: diabetes, liver disease, kidney disease, heart disease or any other serious health issues NWITC may require a history and physical exam and lab work (CBC and CMP) that has been done within the last 90 days.

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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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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?

Patient Name: _____ Counselor: _____ Year (s): _____

OUTCOME: _____

Clinical Signature:

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Patient Agreement to COVID-19 Procedures

During my treatment at NWITC: I, _____, agree to the following: (Please initial next to each requirement)

_____ I agree to wear my own approved mask or the mask provided to me by NWITC at all required times.

_____ I agree NOT to share cigarettes, drinks or any other items that can result in transmission of infectious disease, virus or germs.

_____ I understand that the expectation is designed to create a safe environment for myself, my peers and staff members.

_____ I further understand that failure to follow expectations will lead to disciplinary action and may lead to my discharge from treatment.

Patient Signature

Date

Witness Signature

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 Ramen 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.

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