**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:** 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.

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# 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):**

☒ 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 *****

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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):**

- ☒ 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

***** Confidential *****

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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? (Please include any inhalers and MAT medications)

☐ Yes or ☐ No IF YES, COMPLETE SECTION BELOW

| Medication Name | Dosage and Directions | To treat |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Are you on medication assisted treatment (MAT)?

☐ Yes or ☐ No IF YES, COMPLETE SECTION BELOW *If marked yes please include in the above medications if you have not already.*

**Suboxone** ☐ Yes or ☐ No **Sublocade** ☐ Yes or ☐ No
**Vivitrol** ☐ Yes or ☐ No **Methadone** ☐ 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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**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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**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** | ☐Yes or ☐No | **Insulin dependent?** |
| **Kidney disease** | ☐Yes or ☐No | |
| **Liver disease (hepatitis, cirrhosis, etc.)** | ☐Yes or ☐No | |
| **Heart disease** | ☐Yes or ☐No | |
| **History of heart attack** | ☐Yes or ☐No | |
| **Chest pain** | ☐Yes or ☐No | |
| **Cancer** | ☐Yes or ☐No | |
| **Asthma** | ☐Yes or ☐No | |
| **COPD** | ☐Yes or ☐No | |
| **Tuberculosis or history of positive TB test** | ☐Yes or ☐No | |
| **History of Stroke** | ☐Yes or ☐No | |
| **High blood pressure** | ☐Yes or ☐No | |
| **History of Seizure** | ☐Yes or ☐No | |
| **History of head injury** | ☐Yes or ☐No | |
| **Chronic pain** | ☐Yes or ☐No | |
| **Pregnant** | ☐Yes or ☐No | **Due date?** |
| **Current skin issues (open sores, abscesses, wounds, rash)** | ☐Yes or ☐No | |
| **Immune system suppression** | ☐Yes or ☐No | |
| **OTHER** | ☐Yes or ☐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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# Readmission Questionnaire

NWITC believes that an important aspect of recovery is consistent structure and clear expectations, as well as compassion and warm support. If you were a former patient looking to reenter treatment please answer the following questions:

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?

6. Is there anything else that you would like the staff to know?

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

***Limit items brought to no more than two suitcases, bags or boxes.***
**(Items other than those listed or more than listed will be returned with driver.)**

### Clothing

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

### Personal Items

**(hygiene** items must be alcohol free)

- ☐ Toothbrush, toothpaste, floss
- ☐ Brush, comb, hair gel
- ☐ Package of razors
- ☐ Shampoo, conditioner, soap
- ☐ 1 deodorant
- ☐ 1 lotion
- ☐ 1 package of Q-tips
- ☐ Nail file, clippers, tweezers
- ☐ 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

Patients entering Northwest Indian Treatment Center may bring food items of their choosing with them upon arrival except for **caffeinated beverages, candy, or perishable items**. Food items must also be packaged as single serve (cans of pop versus two-liter bottle). Examples of common food items/items available to purchase during scheduled weekly store runs are listed below.

- Pop (Caffeine **FREE**, single servings)
- Aquafina flavored water: 24 limit
- 100% juice: single serve
- Flavored water
- Gatorade
- Hot Chocolate
- Top Raman or cup of noodle
- Popcorn
- Pretzels-regular
- Already shelled nuts
- Pepperoni sticks / jerky
- Corn nuts
- Peanut butter/cheese crackers
- Crackers
- 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.**

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