For Office Use ONLY
- ☐ Outpatient
- ☐ Intensive Outpatient
- ☐ Residential
- ☐ MAT COAT

(Please check one)

Mountaineer Recovery Center

3094 Charles Town Rd. • Kearneysville, WV 25430 • 304-90l-2070P
Fax 304-885-1054

Patient Demographics and Clinical Referral Screening Information

Name: ______________________________ Social Security #:___________________ DOB:_____________ Age:____________

☐ Copy of ID Obtained Type of ID: _________________________ ID#:________________________________

Address:____

Phone Number: ____

Secondary Phone Number_________________________________

Email:____

Currently Employed: ___________________ Employer: ____

Identify as Male: ______Female: ______ Race: ____________________

Tobacco Use? If yes, what form:

- ☐ Cigarettes
- ☐ Chew/dip
- ☐ Vape pen/mod

(Circle one) Married – Single – Divorced – Separated

Number of Dependents: ________ Highest Level of Education Completed: ___________________________________

Insurance Provider: ________________________________ Policy #:____

Referring Provider:____ Contact Number:_________________________________

Reason for Referral:____

Where were you referred from?____

Information Obtained:

- ☐ Per client report
- ☐ ED (Labs, H & P)
- ☐ Outpatient Treatment Provider

SUD Diagnosis:____

Date of Last Use: _____________________ Substance Used: ____

Amount Used Daily: ___________________

History of:

- ☐ Seizure: If so, when?____________________
- ☐ Hallucinations/delirium tremens (DT's)

If recent Opioid use with likelihood of withdrawal, is patient willing to start Medication Assisted Treatment (MAT) in the form of Buprenorphine/naloxone (Suboxone) within 36 hours of admission? (If not, patient will need to complete a detox prior to admission. MAT stops withdrawal quickly, may be able to admit without detox if willing to start)____

Mental Health Diagnosis:____

Current Medications:____

Community Treatment Providers: ____

Past SUD or Mental Health Treatment: ____

Medical Issues:____

Legal Issues (Pending Court Dates/Parole & Probation): ____

Number of Arrests in last 12 months: _____________ For: ________________________________

Living Situation: ____

Does patient have transportation to and from the Mountaineer Recovery Center?______________________

What level of treatment is patient seeking? Residential Treatment:____________ or Out Patient:____________

Internal Use Only:

Patient Accepted for Admission: ___________ Referred to:_______________________________________

Authorization Completed: Yes____ No____ Authorization #: ______________________________________

Number of Visits Approved: ______________ Authorization Expiration: ___________________________