Main Office #: (508) 754-1865

196 Mechanic Street
Leominster, MA. 01453

Thank you for your interest in the Catholic Charities Leominster Woman's Recovery Home.

We are a "voluntary" 3-6-month Residential Rehabilitation Service for adult women who present with both a Substance Use and Co-Occurring "Enhanced" Disorders. If you are seeking to gain placement on our waitlist, we will make every effort to set up an interview with you. Therefore, we ask that you, along with your clinical team, provide us with the following information in order to begin the referral process *prior* to your placement in our treatment facility.

*Please attach biopsychosocial assessment, a full medication list and most recent TB screen to us at the following email address: LWP_referral@ccworc.org

Date of Referral: ______/_____/________

Name: ___________________________________ ______ ____

Date of Birth: ______/_____/________ Social security number: ____________ - ___________ - _____________

Gender Identity__________________________ Sexual Orientation__________________________

Insurance Plan and number: _______________________________________ #:_______________________________________

Referring Agency and/or Contact Person: ____

Contact number #: ____

Emergency Contact (name, relationship, and phone number): NAME: ____

Relationship to ICE Contact: _________________________________ Contact number: ______________________________

Have you experienced an inpatient psychiatric stay in the past 90-days? Yes: ☐ ; No: ☐ ;

If Yes, please state where? How long of stay? And Discharge outcome(s):

____

____.

Have you experienced more than two emergency department visits for either substance use or mental health reasons in the past year? Yes: ☐ ; No: ☐ ;

Previous Treatment History (total in each) Acute Detox: _______ CSS/TSS: _______ Residential: _______

Are you currently prescribed any form of Medication Assistant Treatment? Yes: ☐ ; No: ☐ ;

If Yes, Names and daily prescribed dose of medication(s): Medication Name: _____________________

Prescriber Name: _____________________________ Daily Dose/mg prescribed: _____________

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*Any Allergies to foods or medications: Yes: ☐ ; No: ☐ ;

If yes, to what foods or medications: ____________________________; ________________________________;

______________________________; __________________________________; _________________________________.

<u>Current Co-Occurring disorders</u>: (DSM-V Diagnoses):

1. ___________________________________ Diagnosed by: ______________________ Year: ______

2. ___________________________________ Diagnosed by: ______________________ Year: ______

3. ___________________________________ Diagnosed by: ______________________ Year: ______

Are you prescribed any medication(s) for any of these diagnoses? **If Yes,** Names and daily prescribed doses of each medication(s):

Medication Name: ________________________________ Daily Dose/mg prescribed: _________________

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Medication Name: ________________________________ Daily Dose/mg prescribed: _________________

Medication Name: ________________________________ Daily Dose/mg prescribed: _________________

Medication Name: ________________________________ Daily Dose/mg prescribed: _________________

Medication Name: ________________________________ Daily Dose/mg prescribed: _________________

List past psychiatric hospitalizations:

Date: ____________ Presenting problem: ____

Date: ____________ Presenting problem: ____

Date: ____________ Presenting problem: ____

Date: ____________ Presenting problem: ____

<u>Current Substance Use Disorders</u>: (DSM-V Diagnoses):

1. ____ Diagnosed by: _________________________ Year: _________

2. ____ Diagnosed by: _________________________ Year: _________

3. ____ Diagnosed by: _________________________ Year: _________

Are you prescribed any medication(s) for any of these diagnoses? Yes: ☐ ; No: ☐ ;

If Yes, Names and daily prescribed doses of each medication(s):

Medication Name: ___________________________ Daily Dose/mg prescribed: ____________________

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Medication Name: ___________________________ Daily Dose/mg prescribed: ____________________

Medication Name: ___________________________ Daily Dose/mg prescribed: ____________________

Substance Use History

Identify substances of choice:	
Primary:	Secondary:
Tertiary:	Quaternary:

Drug	Alcohol	Heroin	Cocaine	Crack	Benzos	Meth	Marijuana	Other Opiate	Other
Amount used									
Frequency									
Method of use									
Age at first use									
Date of last use									

How many times have been in treatment for substance use disorder?

Hosp.	Detox	CSS	TSS	Res. LOC	Sober Living	Sect 35	DUI/OUI	Out-Patient	Partial Hosp.	Peer Support

Have you ever *experienced* a drug overdose? Yes: ☐ ; No: ☐ ;

If Yes; How many overdoses lifetime? _____; How many in the past year? _____;

Have you ever *witnessed* a drug overdose? Yes: ☐ ; No: ☐ ;

If Yes, what was your experience with this? What did you do?
____
____.

Do you currently have a primary care physician? Yes: ☐ ; No: ☐ ;

If Yes; Name: ____

Last date seen: ____

*Other Medical / Co-Occurring Conditions? (e.g. Physically): Yes: ☐ ; No: ☐ ;

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If Yes, Please Explain:

____

____.

If Yes, Names and daily prescribed doses of each medication(s):

Medication Name: ______________________________ Daily Dose/mg prescribed: _____________

Medication Name: ______________________________ Daily Dose/mg prescribed: _____________

Medication Name: ______________________________ Daily Dose/mg prescribed: _____________

Do you currently have any legal issues pending? Yes: ☐ ; No: ☐ ;

If Yes; Explain (open cases, probation, parole, warrants):

____

Do you have an income? Yes: ☐ ; No: ☐ ;

If yes, please explain the source of income____

Do you have children? Yes: ☐ ; No: ☐ ;

If yes, how many under age 18, _________ over age 18__________

Are you currently involved with the Department of Children and Family (DCF)? Yes: ☐ ; No: ☐ ;

If yes, please provide the location of the Area Office in which you are involved_________________________________.

____ Inital here stating you agree to participate in Zoom, FaceTime or other Teleconnect meeting if a face to face interview is not possible.

Please explain what you would like to gain from your treatment here at the Catholic Charities Leominster Woman's Program and how we can best support you during this time

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