Frontier Health Specialty Services Case #: _____

1-877-928-9062 **Turning Point Referral Form**

Date: _____ Referral Time: _____

DEMOGRAPHICS

Name_____

Street Address_____ City_____ State_____ Zip_____

Birthdate_____ Age_____ Social Security Number_____

Insurance/Grant _____ Phone Number _____

Emergency Contact Name & Number _____ Relationship _____

Last Emergency Room visit/where _____

Current Location of client: (Circle One) ER Hospital Floor Walk-In DV Shelter Home Other

Specify: _____ County: _____

Employed: **YES** **NO** Annual Yearly Income: $_____

Reason for referral requesting Substance Abuse Treatment: (Circle most appropriate)

Detox/Residential SI/HI PSYCHOSIS

Experiencing any of the following: (Circle all that apply)

Depression Anxiety Stress Confusion Frustration Memory Loss Mood Swings Bullying
Sleep Disruption Racing Thoughts Rage/Intense Anger Loss of Interest in Daily Life

Suicide and Crisis Risk

Have you had any thoughts of suicide or ending your life in the past week: **YES** **NO**
Have you considered a plan to end your life? **YES** **NO**
If **YES**, please explain**:** _____

Have you had any thoughts of killing or harming someone else in the past week: **YES** **NO**
Do you have an intended victim or thought about how you might hurt someone: **YES** **NO**
If **YES**, please explain: _____

Are you currently experiencing any hallucinations or seeing/hearing things others cannot: **YES** **NO**
If **YES**, please explain**:** _____

In the last week, have you engaged in any self-harming behaviors (i.e. cutting, burning) **YES** **NO**
If **YES**, please explain**:** _____

Legal

Are you currently on probation/parole? **YES** **NO**
Do you have any upcoming court dates? **YES** **NO**

_____

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Substance Abuse History

Drug	Age of First Use?	How Frequently Used?	Last Use?	Route Used	IF APPLICABLE: INITIAL BAL = _____ Time: _____ CURRENT BAL = _____ UDS POSITIVE FOR = _____ Specify specific form/type of drug used
Alcohol					
Opiates/Opioids					
Buprenorphine					
Benzodiazepines					
Hallucinogens					
Cocaine					
Methamphetamine					
Other (Specify)					

Current Detox Symptoms

❒ Convulsion	❒ Night Sweats	❒ Nausea/Vomit	❒ A/V Hallucinations	❒ Blackouts
❒ Chills	❒ Diarrhea	❒ Blood in urine	❒ Shakes	❒ Increased anxiety
❒ BP issues	❒ Headaches	❒ Blood in stools	❒ Muscle spasms	❒ Other: _____
❒ Cravings	❒ Insomnia	❒ Coughing up	❒ Delusions	

□ IV drug use: **YES** **NO**
□ Overdose: **YES** **NO** If yes, when: _____
□ Longest period of sobriety from drug of choice: _____ How long ago? _____
□ Prior treatment: **YES** **NO** If yes, where: _____

Medical

□ Need assistance with ADL's: **YES** **NO** If yes, please list in detail: _____
_____
□ Requires devices to ambulate (e.g. cane, walker, wheel chair): **YES** **NO** If yes, please list in detail: _____
_____
□ Medical Concerns: **YES** **NO** Type: _____
□ Current Medications: _____
□ Pregnant: **YES** **NO** If yes, approximate due date: _____
□ Diabetic: **YES** **NO** If yes, insulin dependent: **YES** **NO**
□ History of seizures: **YES** **NO** Date of most recent seizure: _____
□ Other: _____

VITALS	BP	Pulse	Respiration	Temperature

Referral Source: _____ Contact Number: _____

Please Fax Referral form with any labs available to (423) 461-7016 or scan in encrypted email to TPReview@frontierhealth.org.