



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: _____ ; _____ ;

_____ ; _____ ; _____ .

Current Co-Occurring disorders: (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: _____

List past psychiatric hospitalizations:

Date: _____ Presenting problem: _____

Date: _____ Presenting problem: _____

Date: _____ Presenting problem: _____

Date: _____ Presenting problem: _____

Current Substance Use Disorders: (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):



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Medication Name: _____

Daily Dose/mg prescribed: _____

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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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