Catholic Charities
Leominster Women's Program
196 Mechanic St.
Leominster, MA 01453
Phone (508) 754-1865

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

Once we receive and review your referral we will reach out to update you on the waitlist, estimated bed availability and to schedule a face-to-face interview. This interview is to determine if you meet ASAM criteria for this level of care.

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: _____ 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: ☐ ;

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: _____

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

If yes, to what foods or medications: _____; _____;

_____; _____; _____.

<u>Current Co-Occurring disorders</u>: (ICD-10 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: _____

Medication Name: _____ Daily Dose/mg prescribed: _____

Medication Name: _____ Daily Dose/mg prescribed: _____

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>: (ICD-10 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: _____

Medication Name: _____ Daily Dose/mg prescribed: _____

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 *<u>experienced</u>* a drug overdose? Yes: ☐ ; No: ☐ ;

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

Have you ever *<u>witnessed</u>* 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 / physical health conditions? Yes: ☐ ; No: ☐ ;

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_____.

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

_____

_____

_____

_____

_____

_____

_____