

45-567 PAHIA RD
KANE'OHE, HAWAII 96744

TELEPHONE (808) 262-2799
FAX (808) 262-0970

Referral Source	Date
Name/Title	Telephone

Applicant's Data – (Please Complete Entire Form)

Name _____ Date of Birth _____

Address _____

Telephone _____ Social Security No. _____ Gender: M F Transgender

Has a psychiatrist diagnosed the applicant? Y _____ N _____

Is applicant currently under the care of a psychiatrist? Y _____ N _____

Name of Attending Psychiatrist _____ Telephone _____

Has the applicant ever been in the State Hospital? Y _____ N _____

Has the applicant ever been affiliated with any Hawaii State Mental Health Clinic?
Y _____ N _____

Reason for Referral (Presenting Problems):

Does the applicant have a history of any of the following? **Must Be Answered**

Forensics Status – Legal Encumbrance Y _____ N _____

Violent/Assaultive behavior Y _____ N _____

Suicidal thoughts/attempts Y _____ N _____

Arson or Sex Registry Y _____ N _____

If yes, please describe _____

Does the applicant have a history of sexual and/or physical abuse? Y _____ N _____

If yes, please have applicant describe _____

Does the applicant want to address issues of abuse while in treatment with Po'ailani, Inc?
Y _____ N _____

Current Medications (minimum 2 weeks supply of medication required for admission)

Name	Frequency	Purpose	Last Dose	Effects

Does the applicant take his/her medication as consistently as prescribed? Y _____ N _____

Is he/she capable of administering his/her own medication? Y _____ N _____

Has the applicant consistently taken medication for the last two weeks? Y _____ N _____

Does the applicant have any dental and/or medical problems that will require medical attention and treatment with narcotic medication (i.e., painkillers)? Y _____ N _____

NOTE: Prior approval for admission required from the Medical Director for an individual taking controlled substances.

Any chance that the applicant could be pregnant? Y _____ N _____

If yes, please describe: _____

Previous Psychiatric Treatment History (Begin with last episode)

Has the applicant been hospitalized for psychiatric care in the past for treatment of major mental illness? Y _____ N _____

If yes, please indicate below.

	Treatment Episode	Treatment Episode	Treatment Episode
When			
Where			
Length of Stay			
Level of Care			
Outcome			
What Led to the Relapse			

NOTE: Po’ailani, Inc. requires a copy of a current psychiatric evaluation and/or discharge summary. Please forward copy to the Intake Specialist for consideration of admission into treatment.

Previous Substance Abuse Treatment History (Begin with last episode)

Has the applicant been in treatment for substance use? Y _____ N _____

If yes, please indicate below.

	Treatment Episode	Treatment Episode	Treatment Episode
When			
Where			
Length of Stay			
Level of Care			
Outcome			
What Led to the Relapse			

Vocational Educational History and Interest

Has the applicant completed high school/GED? Y ____ N ____

If the answer to the above questions is no, is the applicant interested in obtaining a GED?
Y ____ N ____

Is the applicant interested in participating in any type of educational program? Y ____ N ____

If yes, what are the interests the applicant? _____

Has the applicant been employed in the past (30) days? Y ____ N ____

Last Month/Year of employment _____ Last Employer _____

Is the applicant interested in participating or returning to work? Y ____ N ____

If yes, what are the work interests of the applicant? _____

Criminal Justice History

Is the applicant presently incarcerated? Y ____ N ____

Do you have a court date?: Y ____ N ____

When is your court date?: _____

Probation Officer/Legal Team	Telephone	Alternate Telephone	Person Notified

If the applicant was previously incarcerated, please complete the following:

CHARGE	MONTH/YEAR	FACILITY	LENGTH INCARCERATED

PO'AILANI'S USE ONLY

Patient Name/ID: _____

ASAM PLACEMENT CRITERIA

Placement Decision			
Key Placement Dimensions (ASAM)		Severity Profile (note) H M L	
1. Acute Intoxication and/or Withdrawal Potential			
2. Biomedical Conditions and Problems			
3. Emotional/Behavioral Conditions and Problems			
4. Treatment Acceptance/Resistance			
5. Relapse Potential/Recidivism			
6. Recovery Environment/Family Support			
6a. Legal			

APPROPRIATE PLACEMENT

(Complete Sections Below)

ADMISSION DATE

TREATMENT MODALITY

Residential	Day	IOP	Outpatient	Modified OP	AC

INAPPROPRIATE/INELIGIBLE

(Complete Sections Below)

REFERRAL DATE

REASON FOR INELIGIBILITY

<u>REFERRAL INFORMATION</u>	

Staff Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Revised 08/15/12, 5,20,13, 7,24,13, 11,7,16, 2.6.18, 10,25,18