LIBERTAE FAMILY HOUSE
PRE-ADMISSION TELEPHONE INTERVIEW

REFERRING AGENCY:________________________________

REFERRING PERSON:________________________

TELEPHONE#_________________________

DATE/TIME OF REFERRAL_____________

CLIENT'S NAME:_________________________

DOB:_____________________

SOCIAL SECURITY#______________________

DOD:_____________________

CLIENT'S HOME ADDRESS:____

____

CLIENT'S HOME PHONE NUMBER:_______________________________

DRUG, ALCOHOL AND PSYCHIATRIC TREATMENT:

DRUG(S) OF CHOICE	LENGTH OF ABUSE	LAST USE
1.________________________	___________________	_______________
2.________________________	___________________	_______________
3.________________________	___________________	_______________

HAVE YOU HAD ANY DRUG AND/OR ALCOHOL ADMISSIONS?:

FACILITY	DATE DIAGNOSIS	DATE COMPLETED
1.________________________	____________________	______________
2.________________________	____________________	______________
3.________________________	____________________	______________

DOES CLIENT HAVE ANY PHYSICAL PROBLEMS? Yes ( ) No ( )

IF YES, EXPLAIN:____

____

IS CLIENT DUALLY DIAGNOSED? YES ( ) NO ( )

MEDICATION:

NAME	AMOUNT	PURPOSE	LAST USE
1.________________________	___________	___________	___________
2.________________________	___________	___________	___________
3.________________________	___________	___________	___________

NAME OF ATTENDING PSYCHIATRIST/PHYSICIAN:_____________________________

ADDRESS:____

PHONE #:____________________________________

LEGAL: IS CLIENT ON: PAROLE ( ) PROBATION ( )

WHAT CHARGE?:_________________________ COUNTY:____________________

PROBATION OFFICER:________________________ PHONE #:_______________

DOES CLIENT HAVE ANY OPEN CHARGES? YES ( ) NO ( )

WHAT ARE THE CHARGES?:____

COUNTY WHERE YOU WERE CHARGED:____

FINANCIAL INFORMATION

IS CLIENT EMPLOYED? YES ( ) NO ( )

EMPLOYER'S NAME:________________________________ PHONE#:_________________

IS CLIENT ON PUBLIC ASSISTANCE? YES ( ) NO ( )

IS CLIENT ON MEDICAL ASSISTANCE? YES ( ) NO ( )

IF YES, WHAT COUNTY?_______________________________

FUNDING INFORMATION:

FUNDING AGENCY:____

PERSON
AUTHORIZING:_______________________________ DATE:____________

PHONE #:______________________

IS CLIENT ON HMO? YES ( ) NO ( ) HMO #:___________________

WHO IS THE PRIMARY CARDHOLDER?______________________________

IF SELF-PAY, ADDRESS AND PHONE NUMBER OF PAYEE DIFFERENT FROM

ABOVE:____

____

CHILDREN'S INFORMATION

DO YOU HAVE ANY CHILDREN? YES ( ) NO ( ) HOW MANY?________

AGE AND SEX OF EACH CHILD 12 OR UNDER:______________________________

(IF CHILD IS OVER 12, HE/SHE IS NOT ACCEPTABLE FOR LFH PROGRAM.)

CHILD'S CURRENT PLACE OF RESIDENCE:

ADDRESS:___________________________________

____ PHONE #_______________

ARE YOUR CHILDREN IN FOSTER PLACEMENT? YES ( ) NO ( )

IF YES, GIVE NAME OF CASE WORKER:__________________________________

COUNTY:______________________________ PHONE #____________________

IS CHILDREN AND YOUTH INVOLVED WITH YOUR FAMILY? YES ( ) NO ( )

IF YES, EXPLAIN:____

PRE-ADMISSION CHECKLIST

PRE-ADMISSION DATA CHECKLIST (To be sent with client or faxed ahead)

___________Psychosocial History

___________Medical/ Physical Exam (with Physician's signature)

___________Psychiatric Evaluation

___________Psychological History

___________Axis I-V Diagnosis with Mental Health Codes

___________TB Test Results (within 6 mos.)

___________Medication Record

___________I.D. Card

___________School Record of each child

___________Insurance/MA Card

___________Record of most recent physical exam of each child (3 mos.)

___________Custody papers (if applicable)

___________Immunization record of each child

Interview Date and Time:_______________________________________

COMPLETED BY:______________________________

DATE:___________________