LIBERTAE, INC.
PRE-ADMISSION TELEPHONE INTERVIEW

REFERRING AGENCY:________________________________ REFERRING PERSON:________________________

TELEPHONE#_________________________ DATE/TIME OF REFERRAL____________

CLIENT'S NAME:_________________________ DOB:_____________________

SOCIAL SECURITY#______________________ DOD:_____________________

CLIENT'S HOME ADDRESS:____
(Street)

____
(City) (State) (Zip Code) (County)

CLIENT'S HOME PHONE NUMBER:_______________________________

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

OTHER TREATMENT (DRUG/ALCOHOL AND PSYCHIATRIC)

FACILITY	DATES	DID CLIENT COMPLETE
1.____________________________	____________________	______________
2.____________________________	____________________	______________
3.____________________________	____________________	______________

DOES CLIENT HAVE ANY PHYSICAL PROBLEMS? Yes ( ) No ( )
IF YES, EXPLAIN:____

IS CLIENT DUALLY DIAGNOSED? YES ( ) NO ( )

MEDICATIONS:

NAME	AMOUNT	PURPOSE	LAST USE
1.______________________	___________	___________	___________
2.______________________	___________	___________	___________

ATTENDING PSYCHIATRIST/PHYSICIAN:________________________

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

WHAT CHARGE?:________________________ COUNTY:___________________

PROBATION/PAROLE OFFICER:_______________________ PHONE #:_______________

DOES CLIENT HAVE ANY OPEN CHARGES? YES _____ NO _____

CHARGES______________________________ COUNTY___________________________

FINANCIAL INFORMATION

IS CLIENT EMPLOYED? YES ( ) NO ( )

IS CLIENT ON PUBLIC ASSISTANCE? ( ) MEDICAL ASSISTANCE? ( )

WHAT COUNTY?______________________________

FUNDING INFORMATION:

FUNDING AGENCY:____

PERSON
AUTHORIZING:___________________________________ DATE:____________

TELEPHONE PHONE_________________________

IS CLIENT ON HMO? YES ( ) NO ( )

IF SELF-PAY, ADDRESS AND PHONE NUMBER OF PAYEE:________________________

____

DATE OF PRE-ADMISSION INTERVIEW _____________________________

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

___________Psychosocial History

__________Psychiatric Evaluation

__________Axis I-V Diagnosis
With Mental Health Codes

___________Medication Record

___________I.D. Card

___________Medical/ Physical Exam
(with Physician's signature)

___________Psychological History

___________TB Test Results (within 6 mos.)

___________Insurance/MA Card

COMPLETED BY:________________________________ DATE:____________________