



Referral and Screening Form

Patient Demographic

Client Name: _____

Date Of Birth: _____ Male or Female: _____

Social Security number: _____

Phone Number: _____

Secondary Phone Number: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Referral Source: _____

Referral Source Contact: _____

Questions:

1. Do you have a guardian? Yes No
2. Do you have someone who has to make medical decisions for you? Yes No
3. How long have you been clean and sober? _____
4. Who is your current service Provider: _____
Your anticipated discharge date: _____

Have you been diagnosed with or have any of the following?

- | | | |
|--------------------------|--|---------------------------|
| Schizophrenia | Hospitalized due to Mental Health | Chronic Pain |
| Schizoaffective disorder | History of Suicidal Ideations | Receiving Pain Management |
| Bipolar disorder | History of Suicidal Attempts | Diabetic I |
| Depression | History of Self-Harming | Diabetic II |
| Anxiety Disorder | Recent Auditory Hallucinations | Mobility Issues |
| PTSD | Recent Visual Hallucinations | Trouble Sitting |
| Other Mental Health | Long-acting injectable antipsychotic medications | Asthma |
| | | History of Seizures |
| | | Seizure Disorder |
| | | Pregnant |

5. Are you currently receiving any medication assisted treatments?

Suboxone Vivitrol
Other

6. Are you Currently locked in to one Pharmacy? Yes No



7. Are you currently prescribed any mental health medications or any other medications?

Medications:

8. Are you a Registered Sex Offender? Yes No
9. Do you need housing? Yes No

Referral Source Information

Please include and/or attach:

1. Full Circle Referral/Screening Form
2. Signed Full Circle Release of Information (Referring Agency Release of Information)
3. Progress Note (last completed)
4. Most recent medical labs
5. Most recent medication lists
6. Discharge Summary
7. Most recent Substance Abuse assessment
8. Copy of terms and conditions of probation and/parole if applying for Re-entry
9. Other: _____

Please Submit to:
info@OhioFullCircle.com -or-
Full Circle Recovery Services (Intake Dept.)
4977 Northcutt Place, Dayton, Ohio, 45414
937-813-4105 (Fax) Intake Coordinator
937-387-6395 (Telephone)
Hours of Operation: 8:00AM-5:00PM Monday-Friday

Full Circle Personnel Information Only

- Billing Verified Insurance
- Approved
- Denied