CSL, Inc. dba FULL CIRCLE RECOVERY SERVICES

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
- ☐ Schizoaffective disorder
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ PTSD
- ☐ Other Mental Health

- ☐ Hospitalized due to Mental Health
- ☐ History of Suicidal Ideations
- ☐ History of Suicidal Attempts
- ☐ History of Self-Harming
- ☐ Recent Auditory Hallucinations
- ☐ Recent Visual Hallucinations
- ☐ Long-acting injectable antipsychotic medications

- ☐ Chronic Pain
- ☐ Receiving Pain Management
- ☐ Diabetic I
- ☐ Diabetic II
- ☐ Mobility Issues
- ☐ Trouble Sitting
- ☐ 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

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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.)
20 Livingston Ave., Dayton, Ohio, 45403
937-813-2757 (Fax) Intake Coordinator
800-829-5461 (Telephone)
Hours of Operation: 8:00AM-5:00PM Monday-Friday

Full Circle Personnel Information Only

- ☐ Billing Verified Insurance
- ☐ Approved
- ☐ Denied