RECEIVED

HOLMAN
RECOVERY CENTER

	INQUIRY MADE
	REVIEWED
	SCHEDULED
	INS. VERIFIED

PLEASE FAX THIS COMPLETED FORM TO: (360) 502-8600

Holman Recovery Center Referral Application

(Please fill this out as thoroughly as possible, even if the information can be found in the assessment)

NAME:_____
Last **First** **MI**

AGE: _____ **DOB:**_____ **SSN:**_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____ **Phone Number:**__(____)_____

REASON FOR REFERRAL:_____

ASSESSMENT COMPLETE: **YES** (if YES, please send a copy with this referral) **NO** **/** **ASAM LEVEL:**_____

ETHNICITY: ☐ African Am. ☐ Asia/PI ☐ Caucasian ☐ Hispanic ☐ NA/AI/AK – TRIBE: _____
☐ OTHER – SPECIFY: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____
PHONE: – –

REFERRING AGENCY: _____ **CONTACT PERSON:** _____
ADDRESS: _____ **PHONE:** – –
CITY: **STATE:** **ZIP:** **FAX:** – –

PROBATION/DOC DEPT: _____ **OFFICER:** _____
☐ Sex Offender Level: ☐ I ☐ II ☐ III **PHONE:** – – **FAX:** – –

HISTORY OF SUICIDE ATTEMPTS, IDEATION, OR SELF HARM? ☐ **YES** ☐ **NO. IF YES, EXPLAIN**

HISTORY OF ASSAULT, ARSON, OR DOMESTIC VIOLENCE? ☐ **YES** ☐ **NO. IF YES, EXPLAIN**

MENTAL HEALTH CONDITIONS:

ANY HOSPITALIZATIONS IN THE LAST THREE MONTHS? ☐ **YES** ☐ **NO. IF YES, EXPLAIN**

MEDICAL CONDITIONS:

CURRENTLY ON MAT? ☐ **YES** ☐ **NO** **MAT PRESCRIBER:**

CURRENT MEDICATIONS:

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ **POLICY ID#:**_____ **GROUP#:**_____

SUBSCRIBER: self other:_____ **SUBSCRIBER DOB:**_____

SECONDARY INS:_____ **POLICY ID#:**_____ **GROUP#:**_____

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E-MAIL: INTAKE@HRCWA.ORG

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