INDEPENDENCE HALL
WHERE RECOVERY GROWS

AGENCY REFERRAL FORM

Referral & Patient Demographics

Referring Agency Contact Person Name

Referring Agency Contact Email Address

Patient Name

Patient Date of Birth

Patient Email Address

Expected Discharge Date

Eligibility & Screening Questions

Has the Patient been admitted to this program before? ◯ Yes ◯ No ◯ Unknown

Does the Patient have a legal guardian or someone who makes legal decisions for them? ◯ Yes ◯ No

Is the Patient a Massachusetts resident? ◯ Yes ◯ No ◯ Unknown

Has the patient served in the military, including the National Guard or Reserves? ◯ Yes ◯ No ◯ Unknown

Does the Patient have a family member who served in the military? ◯ Yes ◯ No

Relationship to family member who served: ☐ Parent ☐ Spouse ☐ Sibling ☐ Child ☐ None ☐ Other:

Is the Patient Pregnant? ◯ Yes ◯ No What trimester?

Does the Patient have legal action pending? ◯ Yes ◯ No

What is the Original Charge(s)?

Does the Patient have any outstanding Warrants? ◯ Yes ◯ No

Outstanding Warrants details:

Is the Patient currently on Probation? ◯ Yes ◯ No

Probation details:

Has the Patient been convicted of Arson? ◯ Yes ◯ No

Has the Patient been convicted of a Sexual Offense? ◯ Yes ◯ No

Substance Use History

List all substances the patient currently uses or has a history of using. Complete one row per substance.

Substance	Age of First Use	Date of Last Use	Frequency of Use	Amount Used	Method of Use	Priority/Drug of Choice Ranking (1 = Highest)

Medication Assisted Treatment

Is the Patient On: ☐ Methadone ☐ Suboxone ☐ Vivitrol ☐ None

What dose of Methadone is the Patient on?
(put N/A if the patient is not on methadone)

Where is the Patient's home clinic?
(put N/A if the patient is not on methadone)

Medical & Psychiatric Information

List any Scheduled Appointments (i.e. Court, DCF, Doctor, etc) including type of the appointment, date/time and location:

Psychiatrist
(name, city/town, phone number):

Has the Patient stopped taking any medications in Past Six Months? ◯ Yes ◯ No

Medication details (name, reason stopped):

Does the Patient have any Acute, or Chronic, Medical or Dental Needs? ◯ Yes ◯ No

Acute, or Chronic, Medical or Dental Needs details:

Does the Patient have Disabilities? ◯ Yes ◯ No

Disability details:

Is the Patient currently taking any Medications? ◯ Yes ◯ No

List all current medications, including Dose, Frequency, Refill information, and Prescriber.

Is the Patient allergic to any medications? ◯ Yes ◯ No

Please list the medication allergies:

Mental Health & Behavioral History

History Of Mental Health Diagnoses? ◯ Yes ◯ No

Please list the Patient's Mental Health Diagnoses:

History of Trauma? ◯ Yes ◯ No

History of Trauma details:

History of Eating Disorders? ◯ Yes ◯ No

Eating Disorder details:

History of Suicide Ideation? ◯ Yes ◯ No

Suicidal Ideation details:

History of Suicide Attempt? ◯ Yes ◯ No

Suicide Attempt details:

History of Homicidal Ideation? ◯ Yes ◯ No

Homicidal Ideation details:

History of Self-injurious Behaviors? ◯ Yes ◯ No

Self-Injurious Behaviors details:

Harm to self or others? ◯ Yes ◯ No

Harm to self and others details:

Assault History? ◯ Yes ◯ No

Assault History details:

RRS Qualification (If Applicable)

Within The Last Three Months Has The Individual Experienced At Least One of the Following:

- ☐ Inpatient Psychiatric Hospitalization
- ☐ At least two Emergency Room and/or ESP Visits
- ☐ Unsuccessful engagement in and/or inability to succeed in other community-based services due to psychosocial or clinical complexity related to substance use and/or mental health disorders
- ☐ N/A

Patient Notification Acknowledgment

Independence Hall CSS Patient Notifications

The referring agency contact person acknowledges by entering his/her initials here _____* that the referred patient has been notified of the following:

1. **Commitment Duration:** Patients must commit to a stay of 14-28 days.
2. **Clothing Limitations:** Patients are allowed 8 days of clothing, which should be packed separately. Excess clothing and other personal possessions will be stored securely, and laundry facilities are available.
3. **Cigarettes:** Patients need to bring a two-week supply or have someone bring a supply bi-weekly.
4. **Personal Belongings:** Patients must designate someone for drop-offs every two weeks for personal items, as there is a limited supply available at Independence Hall.
5. **Counselor Guidance:** Any additional needs must be communicated through the counselor, who will provide guidance on requests.
6. **Medication Compliance:** Patients must bring their medication list and a 14-day supply of medications upon check-in.
7. **Methadone Protocol:** Patients on methadone must have a last-dose letter and approval from their clinic to receive methadone from Spectrum.
8. **Communication Policies:** No cell phone use is allowed during treatment, but patients may make up to three supervised calls per week.

Documentation Submission

All required medical documentation (biopsychosocial assessment, history & physical, medication list, and any clinical records) should be submitted through the initial referral request.

If any additional forms or updated documents need to be submitted after the referral has been sent, they may be faxed to our secure fax line: 855-710-7852.

Please include the patient's full name and date of birth on all submissions.

Program: ☐ CSS ☐ RRS (males) ☐ RRS (females)

Patient SSN:

Patient Insurance Name and ID: