

Bridge House / Grace House Client Referral Form

Full Name (Please Print): _____

Gender: _____ SSN: _____ - _____ - _____ DOB: _____ Age: _____

If Female: Are you pregnant? Yes No Due Date: _____

Race / Ethnicity: _____

Marital Status

Never Married Married Separated Divorced Widowed

Current Address: _____

City: _____ State: _____ Zip: _____ Parish: _____

Contact Number: _____ Contact Name _____

Do you have Medicaid?

Yes No

Do you have Medicare or private insurance?

Yes No

If under 26, are you on your parent's insurance?

Yes No

Are you employed?

Yes No

Other sources of income:

Disability Retirement

Food Stamps

Are you a Veteran?

Yes No

Do you qualify for Veteran Benefits?

Yes No

Current Substance Abuse

Date of last use: _____ Substance: _____ How much? _____

Have you used drugs intravenously? Yes No Date of IV use and Substance: _____

What is/are your drug(s) of choice? Check all that apply

Alcohol Marijuana Heroin Cocaine
 Benzodiazepine "Pain Pills" Methamphetamines Other _____

Legal status for seeking treatment: Voluntary Court ordered

Are you a convicted sex offender? Yes No

Are you currently on probation / parole? Yes No. If yes, please list the Name, Contact Number, Parish, and Reason:

Name of Probation/Parole Officer	Phone Number	Parish

Reason: _____

Are you involved with the Department of Children and Family Services? Yes No. If yes, please list the Name of Case Worker, Contact Number, Parish, and Reason:

Name of Case Worker	Phone Number	Parish

Reason: _____

Have you been arrested in the last 30 days? Yes No How many times? _____

Have you ever committed acts of arson? Yes No

Have you ever tried to harm an animal? Yes No

Do you have any psychiatric diagnosis or other behavioral health issues? Yes No. If yes, please explain: _____

Are you currently having any thoughts about ending your life or wanting to die? Yes No. If yes, please explain: _____

Are you currently having any thoughts about wanting to hurt or harm someone else? Yes No. If yes, please explain: _____

Last Name: _____

Do you have any medication problems? Yes No. If yes, please explain:

Are you currently taking any medications? Yes No. If yes, list them below:

Medication	Dosage	Frequency	When did you start taking it?	Is it effective? Does it work?

Ways to submit our referral:

1. Fax the referral to 504-821-7296
2. Email it to clinical@bridgehouse.org
3. Mail it to 4150 Earhart Boulevard, New Orleans, LA 70125
4. Turn it in at our lobby at 4150 Earhart Blvd during business hours (M-F 8am-4:30pm)
5. Complete online at <https://www.bridgehouse.org/about-us/treatment-programs/>

Hospitals, detox facilities and other treatment programs: Please include the following medical records with the referral:

1. History and Physical
2. TB Test
3. Medication List
4. Nursing Assessment
5. Biophysical History
6. Psychiatric Evaluation
7. Other Pertinent Information

Judicial system / court referrals: Please include a release of information through the court system for our staff to communicate with the court system and any court order mandating treatment

Last Name: _____