Bridge House / Grace House Client Referral Form

Please note that only complete forms will be considered

Date: _____ Expected Discharge Date (Facility or Court referral): _____

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

Provider Name:_____

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

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

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 mental health issues? ☐Yes ☐No. If yes, please explain:_____

_____

Do you currently have a provider for any psychiatric diagnosis or mental health issue? ☐Yes ☐No. If yes, please list the provider:

_____

_____

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:

_____

_____

Do you have any known medical issues or concerns? (diabetes, history of seizures, chronic pain, etc)? If so, please explain:_____

_____

Do you have a provider for any of your medical issues or concerns? ☐Yes ☐No. If yes, please list the provider:

_____

_____

Last Name:_____

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?

Do you currently have a 30 day supply of your medications? ☐Yes ☐No

Who is the current provider of your medications?_____

Are you currently using MAT? ☐ Yes ☐ No

If yes, check current MAT below:

- ☐ Methadone
- ☐ Naltrexone
- ☐ Sublocade Injection – Date of next injection _____
- ☐ Suboxone
- ☐ Subutex (only allowed if pregnant)
- ☐ Vivitrol – Date of next shot _____

Who is your Prescriber/Agency for MAT?_____

Ways to submit our referral

1. Fax the referral to 504-821-7296
2. Email the completed form to clinical@bridgehouse.org
3. Turn it in at our lobby at 4150 Earhart Blvd during business hours (M-F 8am-4:30pm)

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 Assessment
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:_____