



## Referral to Behavioral Health Services Form

Referral to: Sojourner Recovery Services  
1040 University Blvd. Hamilton, Ohio 45011  
Phone: Hamilton (513) 887-0300 Preble (937) 336-5414  
Fax: (513) 785-4495  
Email: [referral@sojournerrecovery.org](mailto:referral@sojournerrecovery.org)

Date of Referral:

\*Please include any supporting documentation

### Referral Source

Referral Source Category: ☐ Agency ☐ Children Services ☐ Drug Court ☐ SAMI Court ☐ Family Court  
☐ Healthcare Provider ☐ Court- Other ☐ Parole ☐ Probation ☐ School ☐ Other

Agency Name:

Referring Staff Name:

Phone:

Fax:

Email:

### Patient Information

First Name:

MI:

Last Name:

Sex:

Alias/Maiden Name:

Date of Birth:

SS#:

Last Known Address:

City:

State:

Zip Code:

County of Residence:

Current Living Situation: ☐ Own Home

☐ Friend/Relative's Home

☐ Homeless

☐ Incarcerated

If incarcerated, please list name of facility:

Anticipated release date:

Reason for incarceration:

Does patient have an open Children Services case? ☐ Yes ☐ No Explain:

Reason for Referral:

Is there a court order for SUD treatment? ☐ Yes ☐ No Explain:

### **Services Requested:**

☐ Comprehensive Assessment

☐ Medication Assisted Treatment

☐ Perinatal

☐ Psychiatry

☐ SUD Intensive Outpatient

☐ SUD Outpatient

☐ SUD Residential\*

**\*If requesting SUD Residential services, please note: If patient has had a prior SUD Residential treatment stay within the past 12 months, Medicaid will require prior authorization for admission.**

Has patient been in SUD Residential treatment within the past 12 months? ☐ Yes ☐ No Explain:

Does patient have ☐ Medicaid ☐ Private Insurance

☐ No Insurance

☐ Other, please explain:

Insurance Company:

Insurance/Medicaid Number:

Has patient applied for Medicaid in the past 30 days? ☐ Yes ☐ No If yes, please explain:

If incarcerated, is patient enrolled in the Medicaid Pre-Release Enrollment Program? ☐ Yes ☐ No Explain:

Does patient have a mental health diagnosis? ☐ Yes ☐ No If yes, please explain:

Is patient receiving mental health services? ☐ Yes ☐ No If yes, please list Agency/Provider:

Does the patient have any health concerns that may impact treatment? ☐ Yes ☐ No If yes, please explain:

Is patient pregnant? ☐ Yes ☐ No Due Date:

Is patient receiving prenatal care? ☐ Yes ☐ No

Is patient currently taking any prescribed medications? ☐ Yes ☐ No If yes, please complete the following:

Prescribed Medication	Is patient compliant with Prescriber order? Y/N	Prescriber	Additional information

**Substance Use Information:**

Substance	Reported Use Y/N	Positive Drug Screen Result Y/N	Date of last Use	Known Frequency	Other pertinent information related to use
Alcohol**					
Benzodiazepines**					
Cannabis/Marijuana					
Crack/Cocaine					
Hallucinogens					
Heroin					
Inhalants					
Methadone					
Suboxone/Subutex					
Prescription Opiates					
Other Sedative/Tranquilizers					
Other					

\*\*If patient is currently using alcohol and/or benzodiazepines, he/she will need to be evaluated to determine if detox is needed prior to entering SUD Residential treatment.

How long was the patient's last period of voluntary abstinence from their preferred substance?

Has the patient experienced withdrawal symptoms during past attempts to stop use? ☐ Yes ☐ No If yes, please explain:

Has patient ever experienced an overdose? ☐ Yes ☐ No If yes, please explain:

Has patient ever been administered Narcan? ☐ Yes ☐ No If yes, please list dates:

Is patient's living environment supportive of recovery? ☐ Yes ☐ No If no, please explain:

Does patient have a recovery support system? ☐ Yes ☐ No Please explain:

Does patient have the skills to maintain recovery? ☐ Yes ☐ No Please explain:

Is patient motivated to seek treatment? ☐ Yes ☐ No Please explain:

Does the patient have any of the following legal charges or convictions? If yes, please attach supporting documentation.

☐ Arson ☐ Assault ☐ Child Endangering ☐ Domestic Violence ☐ Drug Charges ☐ DUI/OVI  
☐ Homicide/Manslaughter ☐ Major driving Violations

Completed by:

Title: