

McLean at Naukeag Ambulatory Treatment Center Self-Referral Packet

NOTE: *To be considered for admission application must be complete in full (If you need assistance with the application call 978-827-5115 ask for admissions*

How did you hear about Naukeag: _____

PATIENT INFORMATION	DATE: _____
Have you been to Naukeag previously? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you being referred by any program or treatment provider? <input type="checkbox"/> N <input type="checkbox"/> Y (name): _____	
Patient Name: _____ Age _____ Gender: _____ DOB: _____	
Address: _____ State/Country: _____ ZIP: _____	
Email: _____ Daytime phone #: _____ Cell #: _____	
Preferred method of contact: <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Cell <input type="checkbox"/> All Best time: _____	

PRESENTING PROBLEM: Check all boxes that describe issues you are currently dealing with:

alcohol problem drug problem depression anxiety trauma issues suicidal ideation
 eating disorder relationship conflict housing/homelessness anger management ADD
 work issues school issues grief issues

Briefly state why you are considering admission to Naukeag at this time:

CURRENT TREATMENT

Do you have current treatment providers? Y N Do you have a psychiatric diagnosis? _____

Name/Agency _____ therapist, psychiatrist, IOP, partial Phone: _____

Name/Agency _____ therapist, psychiatrist, IOP, partial Phone: _____

PAST TREATMENT (ADDICTION & MENTAL HEALTH)			
Treatment Type	# of admits	Facility Name (of most recent treatment)	Dates
Detoxification			
Inpatient Psychiatric			
Residential			
Halfway house			
Sober House			
Intensive Outpatient (IOP)			
Outpatient therapy			
Couple/family therapy			
Suboxone, Methadone maintenance			

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PATIENT NAME: _____

DRUG USE HISTORY					
Primary Drug(s): _____			Secondary: _____		
✓ if used in the past year	Drug	Age First Use	Last Use	Frequency	Amount
	Alcohol				
	Amphetamines				
	Benzodiazepines (Klonopin, Xanax, Valium Ativan)				
	Cocaine				
	Fentanyl				
	GHB				
	Hallucinogens (mushrooms, LSD, PCP, DXM)				
	Heroin				
	Inhalants				
	Ketamine				
	Marijuana				
	MDMA (Ecstasy)				
	Methadone				
	Methamphetamine				
	Morphine				
	Over the counter (cough syrup, Asthma Inhalers, Laxatives, Diet Pills, Cold Medicines, Ephedrine, Sleeping Pills, Benadryl)				
	Oxycontin, Oxycodone, Percocet				
	Rohypnol				
	Steroids (Anabolic)				
	Suboxone				
	Tobacco				
	Other: _____				

MEDICATIONS: List all current medications _____

MEDICAL	Date of Last Physical: _____
Primary Care Physician: _____ Phone _____	
List Any current medical conditions:	

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Pre-Admit Form

Patient Name: _____ Date: _____ Program: ART or PHP
Patient DOB: _____ Age: _____ Telephone #: _____
Address: _____ City/State: _____ Zip: _____

Primary Insurance: _____ Telephone#: _____
Insurance ID#: _____ Group# (if applicable): _____
*Subscriber Name: _____ *Subscriber DOB: _____

Secondary Insurance: _____ Telephone#: _____
Insurance ID#: _____ Group# (if applicable): _____
*Subscriber Name: _____ *Subscriber DOB: _____

Pharmacy Information

In order to be prescribed medication at Naukeag the following information is required. If you don't have a prescription card call your pharmacy and they will be able to give you the information.

Cardholder I.D.: _____ RxBIN: _____
RxGroup: _____ Person Code: _____ Pharmacy: _____
Town: _____ Phone Number: _____
Do you have any allergies? _____
You are responsible for all co-pays which you may pay in cash or by credit card. The card number can be called into the pharmacy.

STOP PROGRAM USE ONLY

FAX TO PT ACCOUNTS 617-855-2366

Is Precertification Required? Y N Telephone #: _____
Information Received: