ODYSSEY HOUSE REFERRAL FORM
4730 Washington Ave, New Orleans, Louisiana 70125

This form is fillable. Use the tab key to move between fields.

Date: _____

_____

Referral Source/Name/Phone Number

1. CLIENT DEMOGRAPHICS:

Name: _____ DOB: _____ Race: _____

Address: _____

Contact Number(s): _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Windowed

Employed: ☐Yes ☐No Other Sources of Income: ☐Disability ☐Retirement ☐Food Stamps

Health Insurance: ☐Medicaid ☐Medicare ☐Private Insurance ☐None

Policy #: _____

2. REQUESTED SERVICE (check one): ☐Detox ☐Residential Treatment ☐Outpatient Treatment

Reason client is seeking services now/motivation for treatment:

_____

3. CURRENT SUBSTANCE USE:

Substance	Method of Ingestion	Amount	Frequency	Age of Onset	Last Use

Is client currently experiencing withdrawal symptoms?

If so, check symptom(s): ☐nausea ☐vomiting ☐headache diarrhea ☐body aches ☐fever ☐stomach cramps

☐muscle cramps ☐muscle twitching ☐shaking ☐increased heart rate ☐insomnia ☐anxiety ☐depression

☐irritability ☐sweating ☐chills ☐anorexia ☐itching ☐electric sensations ☐runny nose ☐yawning

☐sneezing ☐seizure activity

Prior Treatment (list # of treatment episodes/treatment type/if completed:

_____

4. MEDICAL:

Doctor's Name/Phone Number: _____

Is the client pregnant? ☐Yes ☐No if yes, due date: _____

Any known medical problems/concerns (hypertension/diabetes/seizure disorder/history of seizure/stroke/heart attack/chronic pain/HIV/hepatitis)? If so, explain:

Names/Doses of any medications:

Does client have a psychiatric diagnosis or other behavioral health concerns? If yes, explain:

Is client expressing any suicidal ideation, intent, or intent with plan? ☐Yes ☐No

Is client expressing any homicidal ideation, intent or intent with plan? ☐Yes ☐No

Has client ever attempted suicide? ☐Yes ☐No Has client ever attempted homicide? ☐Yes ☐No

If yes to either question, explain: Client has thoughts to cut himself when he is using drugs, doesn't have means or plan to act on it at this point. Client was hospitalized 3 months ago for cutting. Client reports not having thoughts when clean.

If yes, list reason and the name, phone number and parish of officer:

Does the client have any pending court dates? ☐Yes ☐No

If yes, reason, when, and where:

Is the client involved with the Department of Children and Family Services? ☐Yes ☐No

If yes, list reason, name of worker, phone number, and parish:

Fax referrals to: (504) 324-6712 or Email to: detox@ohlinc.org

Main Phone Line: (504) 324-3710

If you have further questions or concerns, email the Program Manager, Tavana Moret at tmoret@ohlinc.org