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

Date: _____

_____
Referral Source/Name/Phone Number

**1. CLIENT DEMOGRAPHICS:**

Name: _____ DOB: _____ Race: _____

Address: _____

Contact Number(s): _____

Marital Status: Single Married Divorced Widowed

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

Health Insurance: Medicaid Medicare Private Insurance None

Policy #: _____

**2. REQUESTED SERVICE (circle 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, circle 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: i.e 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.*

_____

_____

**5. LEGAL:**
Is client on probation/parole? Yes _____ No _____

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 forms to detox@ohlinc.org**

**Main Line: 504-324-3710**