ENIPC – Circle of Life Behavioral Health Network

New Moon Lodge Residential Treatment Center

P.O. Box 969
Ohkay Owingeh, NM 87566
Office: 505-852-2788 Fax: 852-2790

Referral Form

Forms must be complete prior to potential review by clinical admission team. Incomplete forms will delay the admission process.

Referring Agency Information

Name/Title and Agency:
Contact Number:
Fax:
Address:
City/State/Zip:

Client Demographics

Name:
DOB:
SSN:
Address:
City, State, Zip:
Phone number:
Email:
Tribal Affiliation:
Disabilities/Impairments: ☐ Yes ☐ No Describe:
Highest Education Level Completed:
Emergency Contact Name:
Number:

Referral

Voluntary ☐ Yes ☐ No

Legal

Court involved	☐ Yes ☐ No	Court Name and Area:
Probation	☐ Yes ☐ No	
Sex Offender	☐ Yes ☐ No	
Received Sex offender Counseling	☐ Yes ☐ No	With whom and where:
Currently Incarcerated	☐ Yes ☐ No	Where:

Legal involvement details:

Probation/Parole Officer Contact

Name:
Phone Number:
Email Address:
Fax:
Address:
Phone number:
Tribal Affiliation:

Insurance/ Medical

Insurance Provider:
Primary Healthcare Provider (PCP):

Symptoms

☐ Depression	☐ Self- Harm	☐ Hallucinations
☐ Anxiety	☐ Low Self esteem	☐ Physical Aggression
☐ Sleep disturbances	☐ Impulsivity	☐ Hyper active
☐ Change in eating Habits	☐ Poor interactions with peers, family, others	
Other:		

Safety Risks	Current	Historical (behavior > 1 year)	Denies
Suicide Attempt/Gesture	☐	☐	☐
Suicidal Ideations	☐	☐	☐
Self-Harm	☐	☐	☐
Elopement	☐	☐	☐
Physical Aggression	☐	☐	☐
Sexual Perpetration	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

Describe history of any identified safety risks

Substance Use	Current	Age of first use	How often	Date of last use	Denies
Alcohol	☐				☐
Marijuana	☐				☐
Spice (K2 synthetic THC)	☐				☐
Cocaine	☐				☐
Heroin	☐				☐
Methamphetamine	☐				☐
Dextromethorphan (Triple C's)	☐				☐
Other	☐				☐
Other	☐				☐
Other	☐				☐

Withdrawal Symptoms Current

☐ None	☐ Agitation	☐ Nausea/Vomiting
☐ Cramping	☐ Sweating	☐ Hallucinations
☐ Tremors	☐ Seizures	☐ DT's
Other:		

Withdrawal Symptoms Past

☐ None	☐ Agitation	☐ Nausea/Vomiting
☐ Cramping	☐ Sweating	☐ Hallucinations
☐ Tremors	☐ Seizures	☐ DT's
Other:		

Describe history of any identified substances

Precipitating factors leading to need for residential treatment (i.e increased substance use, decrease in social functioning legal actions, loss of job, DUI/DWI, familial death(s), etc.)

Social supports (Identify any and all social supports)

Consumer's Self-Identified Strengths

Are there any current physical illnesses, other than withdrawal, that may need to be addressed due to increased risk or complicated treatment? ☐ Yes ☐ No

Explain

Are there chronic medical conditions that may affect treatment? ☐ Yes ☐No

Explain

Name of Medication	Dosage-mg Times a day	Reason for Medication

Treatment history for substance use

Dates	Inpatient or Outpatient	Length of Stay	Successful discharge Y/N	Facility/Location
	☐In ☐OP		☐Y ☐ N	
	☐In ☐OP		☐Y ☐ N	
	☐In ☐OP		☐Y ☐ N	

Treatment history for mental health services

Dates	Inpatient or Outpatient	Length of Stay	Successful discharge Y/N	Facility/Location
	☐In ☐OP		☐Y ☐ N	
	☐In ☐OP		☐Y ☐ N	
	☐In ☐OP		☐Y ☐ N	

Longest period of sobriety?

Aftercare Recommendations e.g., available resources, accessibility and/or requirements, please include Names/Agency/Location

- CIB
- Medical Clearance
- OTC and Bedside Forms

All of these items must be provided and completed in order for admission into NML.