COWLITZ FAMILY HEALTH CENTER SUD RESIDENTIAL TREATMENT PRE-ADMISSSION INFORMATION AND CHECKLIST

Prior to admission into Cowlitz Family Health Center's (CFHC) SUD Residential Treatment program, please submit to CFHC:

Completed:

- ☐ Legible SUD ASAM assessment that supports the request for residential treatment admission
- ☐ Registration Form (if not seen at FHC for a service in the last 12 months)
- ☐ Health History and Medication Form
- ☐ Patient's health insurance information

Give to the patient:

- ☐ CFHC Residential Treatment Program Information
- ☐ CFHC Residential Packing List

Registration Form
Formulario de inscripción

Please show your services card and/or medical insurance card to the receptionist
Por favor, muestre su tarjeta de servicios y/o tarjeta de seguro médico a la recepcionista

Patient Information *Información del Paciente*			
Name *(Last, First, MI)* *Nombre (Apelido,Propio)*			
Other names you have been known by: *Otros nombres por los que haya sido conocido(a):*			
Birthdate *Fecha de Nacimiento*		**Social Security (optional)** *Seguo Socia (opcional)*	
Mailing Address (Street, Apartment, City, State, Zip Code) *Dirección Postal (Calle, Apartamento Ciudad Estado Código postal)*			
Phone *Teléfono*		**Other Phone** *Otro Teléfono*	
Email Address *Dirección de correo electrónico*		☐ **Not Applicable** *No aplica*	
How may we contact you? *¿Cómo podemos comunicarnos con Ud.?*	☐ **Phone** *Teléfono* ☐ **Mail** *Correo*	☐ **Email** *Correo Electrónico* ☐ **Do not contact** *No contactarme*	☐ **MyChart** ☐ **Other:** *Otro:*
What is your household's monthly gross income (income before taxes)? *¿Cuál es el ingreso bruto mensual de su hogar (ingreso antes de impuestos)?*		**$**	
How many people are in your household (everyone in your tax household)? *¿Cuántas personas hay en su hogar (todos en su hogar fiscal)?*			
Emergency Contact Information *Información en caso de emergencia*			
Name *Nombre*		**Relationship to Patient** *Parentesco con el paciente*	
Phone *Teléfono*		**Other Phone** *Otro Teléfono*	
IF PATIENT IS A MINOR *SI EL PACIENTE ES MENOR DE EDAD*			
Parent/Guardian's Name *Nombre del Padre o tutor*		**Birth Date** *Fecha de nacimiento*	
Employment *Empleo*			
Are you employed? *¿Tiene trabajo?*	☐ **Yes** *Sí*	☐ **No**	☐ **Full Time** *Tiempo completo* ☐ **Part Time** *Tiempo parcial*
What is your occupation? *¿Cuál es su ocupación?*			
Assistance *Asistencia*			
Are you visually or hearing impaired? *¿Tiene alguna discapacidad visual o auditiva?*	☐ **Visually Impaired** *Discapacitados visuals*	☐ **Hearing Impaired** *Discapacidad auditiva*	☐ **No**
Do you need an interpreter? *¿Necesita un intérprete?*	☐ **Yes** *Sí* ☐ **No**	**Are you fluent in English?** *¿Tiene un buen dominio del idioma inglés?*	☐ **Yes** *Sí* ☐ **No**
What is your preferred language? *¿Cuál es su idioma preferido?*			

Registration Form
Formulario de inscripción

Status *Estatus*	
Are you a United States Veteran? ☐ **Yes** ☐ **No** *¿Es Ud. un veterano de los Estados Unidos?* Sí	**Are you a US Citizen?** ☐ **Yes** ☐ **No** *¿Es Ud. un ciudadano de los Estados Unidos?* Sí

Housing Status
Estado de Vivienda

What is your current living situation? Please choose one answer.
¿Cuál es su situación de vivienda actual? Por favor escoja una respuesta.

- ☐ **At risk for homelessness**
  En riesgo de quedar sin hogar
- ☐ **Currently not homeless, but was in the last 12 months**
  Actualmente con hogar, pero estuve sin hogar en los últimos 12 meses
- ☐ **Living in shelter**
  Viviendo en un refugio
- ☐ **Living with friends or family**
  Viviendo con familiares o amigos
- ☐ **Not homeless**
  Con hogar
- ☐ **Street/camp/bridge**
  Calle/Campamento/Puente
- ☐ **Transitional housing**
  Vivienda de transición

How confident are you in filling out forms?
¿Cuánta seguridad siente al completar formularios?

☐ **Not at all** *Ninguna* ☐ **A little bit** *Muy poca* ☐ **Somewhat** *Poca*
☐ **Quite a bit** *Bastante* ☐ **Extremely** *Muchísima*

Identity
Identidad

What is your current gender identity? *¿Cuál es su identidad de género actual?*	☐ **Female** *Mujer* ☐ **Male** *Hombre* ☐ **Trans-Male to Female** *Transexualidad: masculino a femenino* ☐ **Trans-Female to Male** *Transexualidad: femenino a masculino* ☐ **Other:** *Otro*
Do you think of yourself as: *¿Cómo se reconoce a sí mismo(a)?*	☐ **Lesbian or Gay** *Lesbiana o gay* ☐ **Something else** *Otra* ☐ **Straight (not lesbian or gay)** *Heterosexual (ni lesbiana ni gay)* ☐ **Don't know** *No lo sé* ☐ **Bisexual** *Bisexual* ☐ **Other:** *Otro*
How would you like us to address you? *¿Cómo le gustaría que nos dirijamos a usted?*	☐ **She/Her/Hers** *Ella/Ella/De ella* ☐ **They/Them/Theirs** *Ellos/Ellos/De ellos* ☐ **Don't know** *Otro* ☐ **He/Him/His** *Él/Él/De él* ☐ **By Name** *Por mi nombre* ☐ **Other:** *Otro*
Ethnic Group (choose one) *Grupo étnico (elija uno)*	☐ **Hispanic** *Hispano* ☐ **Non-Hispanic** *No Hispano* ☐ **Unknown** *Indefinido o desconocido*
Race (choose one) *Raza (elija una)*	☐ **Alaskan Native** *Nativo de Alaska* ☐ **American Indian** *Indio Americano* ☐ **Asian** *Asiática* ☐ **Black** *Negra* ☐ **Native Hawaiian** *Nativo del Hawái* ☐ **Pacific Islander** *Isleño del Pacífico* ☐ **Unknown** *Indefinido o desconocido* ☐ **White** *Blanca*

Registration Form
Formulario de inscripción

Migrant/Seasonal *Trabajo agrícola*	
Has the principal source of income for you and your family ever been farm work? / *¿Ha sido la fuente principal de ingresos para Ud. y su familia el trabajo agrícola?*	☐ **Yes** ☐ **No** *Sí*
In the past 2 years, did you or any member of your family move here to do farm work? / *¿En los últimos 2 años ¿Ud. o alguien de su familia se mudó aquí para trabajar en campos agrícolas?*	☐ **Yes** ☐ **No** *Sí*
Do you or your family members do farm work on a seasonal basis? /*¿Trabaja Ud. o alguien de su familia en el campo agrícola por temporadas?*	☐ **Yes** ☐ **No** *Sí*

Identification Number *Número de identificación*	
Medicare ID Number *Número de identificación de Medicare*	**Medicaid ID Number** *Número de identificación de Medicaid*
Guarantor Account (The person responsible for paying your bills) *Cuenta del asegurado (La persona responsable de pagar sus facturas)*	
Name *Nombre*	**Relationship to Patient** *Parentesco con el paciente*
Address *(Street, Apartment, City, State, Zip Code)* ***Dirección*** *(Calle, Apartamento Ciudad Estado Código postal)*	
Social Security *Seguo Socia*	**Birth Date** *Fecha de Nacimiento*
Gender ☐ **Female** ☐ **Male** ☐ **Other:** *Género* Mujer Hombre Otro	
Phone *Teléfono*	**Other Phone** *Otro Teléfono*
Insurance Coverage *Cobertura de seguro*	
Subscriber Name *Nombre de suscriptor*	**Relationship to Patient** *Parentesco con el paciente*
Group Number *Número de grupo*	**Suscriber ID** *Número de id. de suscriptor*

Health History – Adolescent/Adult

Historial de Salud – Adolescente y Adulto

	Date / *Fecha*
Name / *Nombre*	**Date of Birth /** *Fecha de nacimiento*

PATIENT HISTORY / *Historia paciente*

Check the box next to any conditions you have now, or have had in the past. / *Marque la casilla junto a cualquiera de los estados médicos que tenga ahora o que haya tenido en el pasado.*

☐ **Allergies** / *Alergias*	☐ **HIV** / *VIH*
☐ **Blood disorders** / *Trastornos en la sangre*	☐ **Heart problems** / *Problemas cardíacos*
☐ **Problems since birth** / *Problemas desde el nacimiento*	☐ **Skin problems** / *Problemas de la piel*
☐ **Thyroid problems/hormone problems** / *Problemas de la tiroides/problemas hormonales*	☐ **Diabetes** / *Diabetes*
☐ **Ears/eyes/nose problems** / *Problemas de nariz/ojos/oídos*	☐ **Stomach problems** / *Problemas del estómago*
☐ **Weight issues** / *Problemas relacionados con el peso*	☐ **Alcohol problems** / *Problemas con el alcohol*
☐ **Tobacco use (chewing/smoking)** / *Consumo de tabaco (masticado/fumado)*	☐ **Genito-urinary problems** / *Problemas genitourinarios*
☐ **Infections** / *Infecciones*	☐ **Injuries** / *Lesiones*
☐ **Kidney problems** / *Problemas renales*	☐ **Gout** / *Gota*
☐ **Brain problems** / *Problemas cerebrales*	☐ **Problems during pregnancy** / *Problemas durante el embarazo*
☐ **Cancer** / *Cáncer*	☐ **Mental health problems** / *Problemas de salud mental*
☐ **Lung problems** / *Problemas pulmonares*	☐ **Bone and joint problems** / *Problemas en los huesos y las articulaciones*

Please use the space below to give more information or to add any condition not listed above / Use el espacio a continuación para dar más información o para agregar cualquier estado médico que no se indique en la lista de arriba:

SURGICAL AND PROCEDURE HISTORY / Historial quirúrgico y de procedimientos

Check the box next to any surgeries or procedures you have had. / *Marque la casilla junto a cualquiera de las cirugías o los procedimientos que haya tenido.*

☐ **Stomach/colon** / *Estómago/colon*	☐ **Heart/blood vessels** / *Corazón/vasos sanguíneos*
☐ **Ears/eyes/nose surgery** / *Cirugía de nariz/ojos/oídos*	☐ **Throat surgery** / *Cirugía de la garganta*
☐ **Bone/joint procedures** / *Procedimientos de huesos/articulaciones*	☐ **Skin procedures** / *Procedimientos de la piel*
☐ **Brain/spine surgery** / *Cirugía del cerebro/columna vertebral*	☐ **Genito-urinary procedures** / *Procedimientos genitourinarios*

Please use the space below to give more information or to add any surgery or procedure not listed above / *Use el espacio a continuación para dar más información o para agregar cualquier cirugía o procedimiento que no se indique en la lista de arriba:*

Health History – Adolescent/Adult
Historial de Salud – Adolescente y Adulto

FAMILY HISTORY / *Historia familiar*	
Check the box next to any conditions that occur in your natural family and list family members by relationship. / *Marque la casilla al lado de cualquier estado médico que se presente en su familia natural e indique a los miembros de la familia por relación*	
☐ **Allergies** / *Alergias*	☐ **Asthma** / *Asma*
☐ **Birth Defect** / *Defecto de nacimiento*	☐ **Bleeding Disorders** / *Trastornos en la sangre*
☐ **Cancer** / *Cáncer*	☐ **Diabetes** / *Diabetes*
☐ **Drug or Alcohol Abuse** / *Abuso de drogas o alcohol*	
☐ **Elevated Cholesterol** / *Colesterol elevado*	☐ **Headaches** / *Dolores de cabeza*
☐ **Heart Disease or Heart Attacks** / *Enfermedad cardiaca ataques cardiacos*	
☐ **Hepatitis** / *Hepatitis*	☐ **High Blood Pressure** / *Presión sanguínea alta*
☐ **Kidney Disease /** *Enfermedad renal*	☐ **Lung Disease** / *Enfermedad pulmonary*
☐ **Mental Illness or Depression** / *Enfermedad mental,depresión*	
☐ **Obesity** / *Obesidad*	☐ **Sickle Cell Anemia** / *Anemia de células falciformes*
☐ **Seizures** / *Convulsiones*	☐ **Stroke** / *Embolia cerebral*
☐ **Thyroid Disease** / *Enfermedad tiroidea*	☐ **Tuberculosis** / *Tuberculosis*
Have any of your natural family members died suddenly, at less than 50 years old, from something other than an accident? / *¿Murió alguno de los miembros de su familia natural de forma repentina, con menos de 50 años de edad, de algo que no fuera un accidente?* ☐ **No** / *No* ☐ **Yes** / *Sí* **Who?** / *¿Quién?:*	

SOCIAL HISTORY / *Historia Social*		
Smoking? *¿Fuma?*	☐ **Current/***Actualmente* ☐ **Past/***Anteriormente* ☐ **Never/***Nunca* **Packs per day***/Cajetillas al día***:**	
Alcohol Use? ☐ **Yes/***Sí* ☐ **No** *¿Consume alcohol?* **Frequency***/Frecuencia***:**		**Drug Use?** ☐ **Yes/***Sí* ☐ **No** *¿Drogas ilícitas?* **Type/***¿Qué tipo?***:**
Education Level: *Nivel Escolar*	**Occupation:** *Ocupación*	**Previous Jobs:** *Trabajos Anteriores*
Are you sexually active? ☐ **Yes/***Sí* ☐ **No** *¿Es usted sexualmente activo?*		**Do you use birth control/contraception?** *¿Usa control de natalidad/anticonceptivos?* ☐ **Yes/***Sí* ☐ **No**
If you are sexually active, is/are your partner(s) / *si usted es sexualmente activo, su pareja es un***:**		☐ **Male /** *hombre* ☐ **Female /** *mujer* ☐ **Both /** *ambos* ☐ **Other /** *otra*

Health History – Adolescent/Adult

Historial de Salud – Adolescente y Adulto

ACTIVITIES OF DAILY LIVING / *Actividades de la vida diaria*	
☐ **Do you exercise regularly?** / *¿Hace ejercicios regularmente?*	☐ **Yes/***Sí* ☐ **No**
☐ **Do you have concerns about your weight?** / *¿Tiene alguna inquietud acerca de su peso?*	☐ **Yes/***Sí* ☐ **No**
☐ **Do you have caffinated drinks/energy drinks?** / *¿Toma bebidas con cafeína/bebidas energizantes?*	☐ **Yes/***Sí* ☐ **No**
☐ **Do you use seatbelts when in a car?** / *¿Usa el cinturón de seguridad cuando viaja en un automóvil?*	☐ **Yes/***Sí* ☐ **No**
☐ **Do you use bike helmets when riding?** / *¿Usa casco cuando monta bicicleta?*	☐ **Yes/***Sí* ☐ **No**
☐ **Are you on a special diet?** / *¿Tiene usted una dieta especial?*	☐ **Yes/***Sí* ☐ **No**
☐ **Have you had a recent blood transfusion?** / *¿Recibió recientemente una transfusión de sangre?*	☐ **Yes/***Sí* ☐ **No**
☐ **Have you had a recent chemical exposure from work?** / *¿Se ha expuesto recientemente a sustancias químicas en el trabajo?*	☐ **Yes/***Sí* ☐ **No**
Please use the space below to give more information / *Use el espacio a continuación para dar más información:*	

OBSTETRICAL HISTORY - FEMALE ONLY / *Obstetricia - Únicamente para Mujeres*	
Number of pregnancies *Número de embarazos*	**Number of miscarriages** *Número de malpartos*
Number of children born alive *Número de nacimientos vivos*	**Number of stillbirths** *Número de nacimientos sin vida*
Number of premature births *Número de nacimientos prematuros*	

Health History – Adolescent/Adult
Historial de Salud – Adolescente y Adulto

MEDICATIONS LIST
LISTA DE MEDICAMENTOS

MRN:

Name / *Nombre*:	**Date of Birth** / *Fecha de nacimiento*:	**Date** / *Fecha*:
Allergies / Adverse Reactions / *Alergias / reacciones adversas:*		
Vitamins? /*¿Vitaminas?* ☐**Yes** / *Sí* ☐**No**	**Flouride?** /*¿Fluoruro?* ☐**Yes** / *Sí* ☐**No**	

Date / *Fecha* **Start** / *Iniciar*	**Stop** / *Detenerse*	**Medication** / *Medicamento*	**(Dose / Frequency)** *Dosis / frecuencia de suministro*	**Reason for Medication** / *Motivo para usar el medicamento*

COWLITZ FAMILY HEALTH CENTER
SUBSTANCE USE DISORDER TREATMENT RESIDENTIAL PROGRAMS INFORMATION

RESIDENTIAL TREATMENT PROGRAMS
FHC operates two residential treatment programs. PPW (Pregnant and Parenting Women) Program accepts women and their children under the age of six. Treatment stay is 6-9 months. TRC (Toutle River Campus) accepts single adults. Treatment stay is typically 1-3 months.

TREATMENT EXPECTATIONS
Our facilities are ADA compliant. Patients need to request any needed disability accommodation prior to entering treatment with us. CFHC reserves the right to determine if we are able to provide the accommodation requested.

We expect all of our patients to be able to care for themselves independently (not need assistance with toileting, showering or getting around the facility).

We expect all of our patients to be respectful and courteous to all people within the treatment setting, including staff and fellow patients.

All patients are expected to participate in treatment groups, support their peers, and keep themselves and each facility drug-free. We expect patients to work with their counselors to complete goals and gain knowledge to meet their treatment goals.

The first 72 hours of the patients' stay are considered a "Blackout" period. During the blackout period, patients have limited access to their personal items (to allow staff the time to thoroughly search), are only to make business or child telephone calls, cannot have outside visitors, and must be accompanied by another patient to all off-site appointments.

All new patients are assigned a "big brother/sister" upon their entry to our residential facilities.

DRUG TESTING
Patients are randomly tested during treatment for drug or alcohol use. Staff collects urine samples for laboratory testing and/or conducts breathalyzer tests.

DRESS CODE
Patients are expected to present a neat and clean appearance and dress appropriately during their stay. Patients are encouraged to dress in comfortable clothing that is modest and non-offensive to others.

FACILITY CLEANLINESS
All patients are expected to keep their living spaces tidy and organized and to complete assigned chores.

TELEPHONE GUIDELINES
All patients have phone time each week. Sign up on the phone sign-up sheet for the desired phone time.

TRANSPORTATION SERVICES
Each facility provides transportation for patient appointments and group activities. Patients should request transportation for appointments and/or out-of-facility activities from staff at least 24 hours prior. Transportation availability is dependent on available staffing.

STORAGE OF PERSONAL ITEMS

Patients may store personal items (toiletries, hygiene items, etc.) needed during the course of their treatment stay in designated storage lockers/cubbies that they have access to. Permitted items in the quantities identified on the packing list are stored in the patient's room. Unpermitted items or items exceeding quantities on the packing list will be sent back with the patient's family, stored by CFHC in locked storage offsite or discarded.

VISITORS

Patients participating in the Pregnant and Parenting Women Program are able to have outside visitors on designated visiting days. Prior to visiting, visitors aged 18 and over must attend an Al-anon or Nar-anon meeting. CFHC reserves the right to search and/or drug test visitors. We ask that visitors leave all of their personal items in their cars while attending our visiting hours.

Due to the shortness of the treatment stay, patients participating in the Toutle River Campus Program are able to have outside visitors only by special arrangement with the treatment team.

MEDICATION MANAGEMENT

All prescription and over-the-counter medications will be stored in a locked area on site. Patients are responsible for requesting access to their medications when they are scheduled to take them.

RELATIONSHIP GUIDELINES

All patients are prohibited from dating, flirting, sexual contact, or harassing behavior towards or with other clients or staff members.

COMPLIANCE WITH PRIVACY LAWS

CFHC (i) is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d and 45 CFR parts 160 and 164) ("HIPAA"), (ii) operates a substance abuse treatment program that is bound by 42 CFR Part 2, and (iii) is a certified residential treatment facility that is subject to applicable provisions of RCW 71.24 and WAC 246-341. Substance abuse treatment records are protected by the listed laws and regulations and cannot be disclosed without the patient's written consent unless otherwise provided for under applicable law.

WELCOME TO FAMILY HEALTH CENTER!

Please bring your photo ID and your current Insurance / WA Apple Health / ProviderOne cards with you.

Pack two (2) weeks' worth of the following items. Please be mindful of the amount of clothing coming into the facility.

1. Comfort blanket or throw
2. Slippers (something must be worn on the feet at all times)
3. Shoes - athletic, canvas, etc. (comfortable – closed toe for safety)
4. Flip/flops or shower shoes
5. Coat or jacket
6. Sweatshirt(s)
7. Pants (jeans, yoga pants, etc.)
8. Shorts (athletic and/or casual – fingertip length – seasonal needs vary)
9. Pajamas, sweats, sleep wear (must bring sleeping apparel of some sort with you)
10. Tops/shirts (short or long sleeved – no tank tops/spaghetti straps allowed)
11. 2 week supply Underwear/bra(s)
12. Bathrobe (recommended)
13. Business casual/professional outfits and shoes for court, meetings, etc. (if applicable)

In addition to clothing, you may pack a reasonable amount of the items below:

- Prescribed medications you are currently taking in the original bottle from the pharmacy (FHC will store your medications in a locked location during your stay)
- Cell phones (FHC will store your cell phone in a locked location during your stay)
- TRC residents - up to 3 store bought and sealed snack items and tobacco products to last the duration of their stay
- Stamps/envelopes
- Sugar Free gum
- Alarm clock/radio/CD player with headphones/earbuds
- Appropriate reading material (recovery based, parenting, self-help, etc.)
- New and unopened unscented shampoo, conditioner, toothpaste and unscented deodorant (if alcohol is listed as one of the first three ingredients in your hygiene products, we will need to keep them in another location during your stay). **Hygiene products are provided if needed.**

PPW clients: please bring the following items for your infant(s)/children:

- Required: Proof of Immunization records for each infant/child
- Diapers
- Formula (PPW will provide – bring what you have)
- Bottles (PPW will provide)
- Enough clothing for two weeks (14 outfits and 14 pairs of pajamas)
- Stroller and Car Seat
- Small toys/comfort items

Reminder: Please note that if you leave our program, we will only hold your items for 45 days. If you have not made arrangements for pick-up by that time, we reserve the right to donate your items to a local charity. Family Health Center is not responsible for any lost or stolen items.

PLEASE DO NOT BRING THESE ITEMS WITH YOU

- Sheets/pillows
- I-pods containing photos or movies
- Jewelry or valuables
- Weapons
- Drugs or drug paraphernalia
- Cologne, perfume or other fragrances for the body
- Incense, candles or air freshener of any kind
- Offensive words/symbols/images on clothing
- Money over the amount of $30.00
- Medications without a prescription – written consent from a medical provider is required for prescription AND over-the-counter medications for adults and infants/children.
- Pornographic material of any kind
- Portable DVD players
- Vehicles (please do not drive your own vehicle to the facility)

FAMILY HEALTH CENTER WILL PROVIDE THE FOLLOWING DURING YOUR STAY

- Sheets/pillows/blankets/comforters
- Meals for adults and infant(s)/children
- Laundry soap
- Shampoo and conditioner
- Shower soap or body wash
- Feminine products
- Razors
- Deodorant
- Toothpaste
- Toothbrush
- Paper and envelopes
- Diapers
- Formula
- Bottles