BRANTWOOD
FAMILY SERVICES

Residential Treatment Referral

**Please complete referral form in its entirety.*

Client Name: _____ DOB: _____

Address:

_____

_____

County of Residence: _____ Phone #: _____

Medical Insurance & ID # _____

Date residential services are needed/requested: _____

Current DSM5 Diagnoses: _____

_____

_____

_____

Current Health Conditions: _____

_____

Current Medications & Prescribers: _____

_____

_____

_____

For Pregnant & Parenting Women Program

Pregnant/Due Date: _____ OB/GYN: _____

Children/Ages: _____

_____

Names/Ages of children that will need to reside with mother: _____

_____

Referring Treatment Provider/Contact Info: _____

_____

_____

Does your client meet the following criteria? _____

Residential Admission Criteria:

- Female, at least 18 years of age
- Primary SUD diagnosis
- No signs of acute withdrawal
- Medical problems are stable and do not require medical monitoring; Able to self-administer medication
- No acute psychiatric conditions
- Expresses a desire to change substance use
- Limited coping skills; high risk for relapse
- Lacks a supportive recovery environment
- No open arrest warrants, and is not a fugitive of any jurisdiction
- No criminal history of sexual assault/abuse or arson.

Please attach the following and fax to **410-398-0218**

- ✓ Signed Release of Confidential Information
- ✓ Medical insurance card
- ✓ Assessment information, relevant clinical history obtained by referral source

_____ _____

Signature of Person Completing Referral Date

For Internal Use

Received: _____ Screening scheduled: _____

Outcome: _____

_____