LAKE WHATCOM
Residential & Treatment Center

# BAKER CREEK CO-OCCURRING RESIDENTIAL TREATMENT PROGRAM Referral

## Pre-Admission Assessment

***(The following information is required prior to application approval)***

| | | |
|---|---|---|
| Name: | Phone #: | SS#: |
| Ethnicity: | DOB: | Age: |
| Address: | | |
| Pronouns: | | |

| | | |
|---|---|---|
| Referring Agency/CM: | | Referring Phone #: |
| Guardian: ☐ No ☐ Yes<br>If Yes, Who? | | |
| Emergency Contact: | Phone #: | Relationship: |
| Source of Income: | Income Amount: | LWC Payee: No ☐ Yes ☐<br>or Other payee (who)? |
| Medicaid: ☐ No ☐ Yes | NAME OF MCO | Provider ONE #: |

Current Placement Status: ☐ Homeless ☐ Apartment ☐ With Family ☐ Jail/Prison ☐ Inpatient Psychiatric ☐ Other (specify):

If currently hospitalized, list hospital: Date of Admission:

Reason for Admission:

Does the Client have a Community Mental Health Provider? YES ☐ NO ☐ If yes who?
Name/address/number:

Does the Client have a Community Mental Health Provider who is following client's medications?
Name/address/number:

Does the Client have a PCP? YES ☐ NO ☐ If yes who?
Name/address/number:

**Behavioral Health**

Mental Health Diagnosis INCLUDE DSM-V F CODES

| | | | |
|---|---|---|---|
| Primary: | | | |
| Secondary: | | | |
| Other: | | | |
| Last MH Provider: | | Last MH Intake Date: | |

Substance Use INCLUDE DSM-V F CODES

| | | | |
|---|---|---|---|
| ASAM Level of Care: | | Last ASAM Date: | |
| SUD Diagnosis: | | | |
| Clinician Drug Use Rating: | **1. Abstinent**: no use of drugs during this time period.<br>**2. Use without impairment**: use of drugs during this time period but no evidence of persistent or recurrent problems related to use or dangerous use.<br>**3. Abuse:** use of drugs and evidence of persistent or recurrent problems related to use or recurrent dangerous use.<br>**4. Dependence:** meets at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of drug use, continued use despite | | |

| | |
|---|---|
| | knowledge of alcohol or substance-related problems, marked tolerance, characteristic withdrawal symptoms.<br>**5. Dependence with Institutionalization**: Problems related to dependence are so severe that they make non-institutional living difficult. |
| Substance of Choice: | Primary:<br>Secondary:<br>Other: |

**Functional Assessment**

Assess client functioning, strengths and preferences in the following areas:

**Legal Problems/history** (including Less Restrictive Orders, Probation, Parole, Charges Pending, Court Orders)

- ☐ No issues
- ☐ Legal issues: Explanation (including needs/strengths/preferences): _____
- ☐ LRO: If so who is following them? _____

**Role Performance** (school, work, parenting, etc):

- ☐ No issues
- ☐ Needs: Explanation (including needs/strengths/preferences): _____

**Cultural/Spiritual:**

- ☐ No issues
- ☐ Needs: Explanation (including needs/strengths/preferences): _____

**Awareness of Personal Safety issues**:

- ☐ No issues
- ☐ Needs: Explanation (including needs/strengths/preferences): _____

**Does client currently smoke cigarettes?**

- ☐ Yes
- ☐ No Explanation: _____

If answered "Yes" to above question, please complete below:

Ability to Smoke Unsupervised: _____

**ADLS** (toileting/incontinence, ambulating, bathing, medication management, dressing, personal hygiene, specialized body care, etc.)

- ☐ No issues
- ☐ Needs: Explanation (including needs/strengths/preferences): _____

**Significant known behaviors:**

- ☐ Suicide Risk
- ☐ Sexual inappropriate
- ☐ Arson
- ☐ Social Visits/ Outings
- ☐ Anger Outburst
- ☐ Threatening/assaultive
- ☐ Wandering/exit seeking
- ☐ Other (e.g. impulsivity, mobility, access to weapons)

Comments: _____

**Preferences** regarding other issues important to the applicant, such as food and daily routine: _____

**Stressors/Triggers**: _____

**Coping skills** client can readily access to assist when experiencing behavioral health crisis: _____

**Client Strengths** capabilities, resources, beliefs, values, goals, hopes, self-concept, existing social and familial resources, motivation sources: _____

**Residential History:** Has the client lived in residential facilities in the past? ☐ No ☐ Yes, if yes list facilities/length of stay and reason for leaving: _____

**Violence History:** Does the client have a recent history of violence?_____ Are there any known ***NO CONTACT ORDERS*** in place at this time?_____

Are there any court ordered treatment required due to violence? _____

**Specialty DX:** Does the client have any diagnosis related to being developmentally disabled? _____

Does the client have an eating disorder or any other dx's that may require specialty certification/training? If yes please list it here. _____

**SUBSTANCE USE:**

**Will client need detox for benzo's, alcohol, or opiates? _____**

**Is the client at risk for seizures when withdrawal/detox?_____**

**Substance 1 Used**: _____ **Last Use Date**: _____ **Route of Use:**_____ (Oral, Injection, Inhalation, Smoke)
**Substance 2 Used**: _____ **Last Use Date**: _____ **Route of Use:**_____ (Oral, Injection, Inhalation, Smoke)
**Substance 3 Used**: _____ **Last Use Date**: _____ **Route of Use:**_____ (Oral, Injection, Inhalation, Smoke)

## Medications

Current Prescribed Psychiatric Medications:

**Does client have access up to 60 to 90 days' worth of current prescriptions (as BCRTF does not provide in-house direct prescribing services)?** ☐ No ☐ Yes

If **NO**, what is the plan for client to obtain continued access to current prescriptions? _____

If **YES**, how is client receiving 90 days' worth of current prescriptions (mediset/bottles/etc)? _____

***NOTE: As BCRTF does not have in-house prescribing capabilities, clients will need to have access to medications during their treatment stay, which can last up to 180 days. If the client is not a Whatcom County resident, the client will need to have their prescriber follow their meds while at BCRTF.***

**Current Psychiatric Medications**

| Name of Medication | Dose | Prescriber's Name |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| | | |

**Current Prescribed Non-Psychiatric Medications**

| Name of Medication | Dose | Prescriber's Name |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Current Over-The-Counter Medications (must be approved by their provider)**

| Name of Medication | Dose | Prescriber's Name |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## ALL ALERGIES Food? Medications? Gluten….

| |
|---|
| |
| |

## Continued Medical Section

When is the client's next if any medical appointments? _____

Does the client have any signs of MRSA/open wounds/abscess, or any medical conditions? _____If "YES" client will need medical clearance for treatment through medical provider, and we will have to follow up with our medical staff to further discuss these concerns.

Has the client had a COVID vaccination? _____Can you obtain copies of the vaccination records?

Does the client need to use any medical instruments such as a cane/walker/crutches or any other devices to walk? _____

Does the client require the use of any medical equipment such as CPAP/oxygen tanks, or any other devices? _____

Can the client utilize an upper bunk? _____

Is the client able to climb stairs? _____

**BCRTF REFERRAL DECLARATION**

| Client Name: | DOB: | Date: |
|---|---|---|
| SS #: | Phone: | Ethnicity: |
| Address: | | |

My relationship to the referred client listed above is: ☐ Self ☐ Other

If "OTHER":

| Name/Agency: | Relationship to client: |
|---|---|
| Time known client: | Date of most recent contact: |

Does individual requesting admittance have Medicaid/Medicaid eligible? ☐ Yes ☐ No If "NO" Explain: _____

Individual has a substance use diagnosis and/or ASAM LOC? ☐ Yes ☐ No If "NO" Explain: _____

Individual has a mental health diagnosis? ☐ Yes ☐ No If "NO" Explain: _____

Individual requesting admittance understands that BCRTF is a co-occurring residential treatment facility aimed to assist individuals with substance use and mental health concerns? ☐ Yes ☐ No If "NO" Explain: _____

Does individual requesting admittance understand that he/she/they will have a roommate while residing at LWC BCRTF? ☐ Yes ☐ No If "NO" Explain: _____

Individual requesting admittance is medically stable and does not require 24-hour medical or nurse monitoring and can address medical/physical concerns independently? ☐ Yes ☐ No If "NO" Explain: _____

Individual requesting admittance has been explained medication support services available and agrees to taking medications as prescribed? ☐ Yes ☐ No If "NO" Explain: _____

Risk Assessment:

Insight in behavioral health diagnosis? ☐ Yes ☐ No If "YES" Explain: _____
Engage in impulsive decisions/behaviors? ☐ Yes ☐ No If "YES" Explain: _____
Possess or have access to weapons? ☐ Yes ☐ No If "YES" Explain: _____
Ability to make safety needs known? ☐ Yes ☐ No If "YES" Explain: _____
Independently mobile (can use stairs/low fall risk/no staff assistance required)? ☐ Yes ☐ No If "NO" Explain: _____

If individual was accepted, what are the goals they would hope to achieve while staying at LWC BCRTF? _____

Individual will be able to smoke while on site. Smoking is allowed. Has the individual been informed that Smoking Safety Policies and Substance Use Policy violations could result in LWC BCRTF discharge? ☐ Yes ☐ No If "NO" Explain: _____

As LWC BCRTF is a Residential Treatment Facility, all staff are mandated to report elderly/child/vulnerable adult abuse, neglect and/or exploitation. Individual understands engaging in the above behaviors can result in LWC BCRTF's inability to meet resident needs and possible discharge? ☐ Yes ☐ No If "NO" Explain: _____

Individual understands Emergency Contacts can be notified if a resident has eloped? ☐ Yes ☐ No If "NO" Explain: _____

Current medication orders can be sent to BCRTF/Hoaglands/Genoa? ☐ Yes ☐ No If "NO" Explain: _____

_____ _____

Individual/Representative Signature: Date:

# Lake Whatcom Center - GAIN-SS

Demographic Information and GAIN-SS (Self Report) **Complete by Consumer**:

| Date | Last Name | First Name | Middle Name | Date of Birth | Gender |
|---|---|---|---|---|---|
| | | | | | ☐ Male<br>☐ Female<br>☐ Transgender<br>☐ _____ |

By answering the questions in this checklist, you will help your treatment provider understand what treatment you may need. This information will help you and your treatment provider develop the best possible plan of treatment for you. Your answers will also help to improve the mental health care in your community.

Completing this checklist is optional. If you are willing to answer the questions, please complete the survey and sign your name at the bottom of this page. If you do not wish to answer the questions, please tell your treatment provider and give the checklist back to your treatment provider.

**Global Appraisal of individual Needs — Short Screener (GAIN-SS)**

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

**Please check Yes or No**.

| | | |
|---|---|---|
| **During the past 12 months, have you had significant problems…** | | |
| A. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? | ☐ YES | ☐ NO |
| B. with sleep trouble such as bad dreams, sleeping restlessly or falling asleep during the day? | ☐ YES | ☐ NO |
| C. with feeling very anxious, nervous, tense, fearful, scared, panicked or like something bad was going to happen? | ☐ YES | ☐ NO |
| D. when something reminded you of the past, and you became very distressed and upset? | ☐ YES | ☐ NO |
| E. with thinking about ending your life or committing suicide? | ☐ YES | ☐ NO |
| IDS Sub-Scale Score (0-5) | | |
| **During the past 12 months, did you do the following things two or more times?** | | |
| A. Used or conned to get things you wanted or to avoid having to do something? | ☐ YES | ☐ NO |
| B. Had a hard time paying attention at school, work or home? | ☐ YES | ☐ NO |
| C. Had a hard time listening to instructions at school, work or home? | ☐ YES | ☐ NO |
| D. Been a bully or threatened other people? | ☐ YES | ☐ NO |
| E. Started fights with other people? | ☐ YES | ☐ NO |
| EDS Sub-Scale Score (0-5) | | |
| **During the past 12 months did…** | | |
| A. you use alcohol or drugs weekly? | ☐ YES | ☐ NO |
| B. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effect of alcohol or drugs (high, sick)? | ☐ YES | ☐ NO |
| C. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? | ☐ YES | ☐ NO |
| D. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events? | ☐ YES | ☐ NO |
| E. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or did you use any alcohol or drugs to stop being sick or avoid withdrawal problems? | ☐ YES | ☐ NO |
| SDS Sub-Scale Score (0-5) | | |

Client Signature _____ Date _____

***NOTICE TO REFERANT: The following documentation must be included in the referral package in addition to the completed Admission form.***

☐ Current SUD (6 months or more recent) *ASAM Assessment LOC 3.3 – 3.5, and/or SUD Diagnoses by a provider*

☐ Last Mental Health Intake (assessment) that indicates *Mental Health and/or SUD Diagnoses/Co-Occurring*

☐ Current medication list

☐ Clinical/Medical Recent documentation (prescriber notes/evaluations)

☐ Client completed GAIN SS

☐ Client completed Referral Declaration

## FOR LWC USE ONLY

Recommendation for admission: ☐ Yes ☐ No Explain: _____

Reviewer: Date:

Request is: ☐ Approved ☐ Not Approved (include reason): _____

_____

BCRTF Supervisor Date