ST LAWRENCE HEALTH
An Affiliate of Rochester Regional Health

Inpatient Substance Use Disorder Services

Legal Name: _____ **Preferred Name**_____ **DOB:** _____

Phone #:_____ **SS#:** _____ **Address:** _____

Do you have safe housing? ☐**Yes** ☐No

Sex at Birth: ☐Male ☐Female **Gender Identity**: _____ **Gender Expression**:_____

Pronouns: ☐She/Her ☐He/His ☐They/Them ☐Ze/Hir ☐Ze/Zir _____

Insurance: ☐MCD ☐MCR ☐UHC ☐FID ☐TRI ☐BCBS ☐EMP ☐OTH: _____ ID #: _____

Current Pregnancy, or concern for losing custody of children? ?☐No☐Yes, Details: _____

	Substance	Primary Route	Last Used	Amount Used	Frequency	Age Use Began
Primary Substance						
Secondary Substance						
Tertiary Substance						

History of: ☐Seizures ☐Blackouts ☐Overdose ☐Using in Hazardous Situations/Amounts or Frequencies

Medical History: _____

Mental Health History: _____

Medications:_____ **Independent of ADL's**? ☐**Yes**☐No

Currently on MAT (Medication Assisted Therapy), program? ☐No ☐Yes **Details:** _____

History of suicidal or homicidal ideations/attempts? ☐No ☐Yes When/Method _____

Legal Involvement? ☐No ☐Yes Type: ☐Probation ☐Parole ☐Current/Pending Charges ☐ Recently Released
Details: _____

Any preferences for a counselor (gender, approach, personality, etc)?_____☐No Preference

We incorporate pet therapy into treatment, any allergies, concerns or fear of dogs? ☐No ☐Yes

Do you have family or a significant other in our program at this time? ☐No ☐Yes, Details
Referral Source and Contact Info: _____

COVID Screen: _____ Ins: _____ SO: _____SS: _____

Additional Information: