UNITY HEALING CENTER ADMISSION APPLICATION

Date of Application: _____

Patient Information:

Last Name:_____First Name:_____Middle Name:_____

Other Name/Aliases:_____Date of Birth:_____

Sex:_____Marital Status:_____Primary Language:_____

Tribal Affiliation:_____

Religious Preference:_____Ethnicity:_____Race:_____

Place of Birth (City/State):_____

Medicaid: Yes ☐ No ☐ Policy Number:_____Effective Date: _____

Other Health Insurance: Yes ☐ No ☐ Name of Insurance:_____

Policy Number: _____Effective Date:_____

Family Information:

Mother's Name:_____Phone Number: _____

Mother's Address:_____

Father's Name:_____Phone Number:_____

Father's Address:_____

Patient's Current Placement:

Home ☐ Other Family ☐ Hospital ☐ Foster setting ☐ Juvenile Detention ☐

Name of Legal Guardian:_____Relationship to Patient _____

Phone Number: _____ Legal Guardian's Address:_____

E-Mail:_____

Educational History:

Name of last school attended:_____City/State:_____

Grade in school:_____Attending special education classes? ☐ Yes ☐ No

Has the patient ever been suspended or expelled from school? ☐ Yes ☐ No

If yes, please explain why: _____

_____

Indian Health Service, Unity Healing Center, Cherokee,	**Patient Information**	
Program: Intake and Aftercare Services	Name:	
Policy Reference: Admission Criteria CTS-01	Date of Birth:	
Assigned Counselor:	HRN:	

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Does the patient currently have a documented learning disability? ☐ Yes ☐ No

Does the patient have a current IEP? ☐ Yes ☐ No

Other school related comments: _____

Legal History:

Current and/or pending legal charges? ☐ Yes ☐ No

If yes, please describe:_____

Is the patient currently on probation? ☐ Yes ☐ No

Is the patient court ordered for treatment? ☐ Yes ☐ No

Social Service/Indian Child Welfare Involvement? ☐ Yes ☐ No

If yes, please describe:_____

Emotional/Behavioral:

Does the patient have history of elopement (running away)? ☐ Yes ☐ No

If yes, please explain: _____

Does the patient have a current or history of physical violence/aggression toward others? ☐ Yes ☐ No

If yes, please describe: _____

History of suicidal ideation/attempt/self-harm? ☐ Yes ☐ No

If yes, please describe (including dates):_____

Substance Use Diagnosis:

Current/past Substance Use Disorders (SUD):_____

Describe current/past course of treatment (inpatient and/or outpatient) for SUD: _____

_____

Current and/or past Comorbid Mental Health Conditions: _____

_____

Reason for referral:

_____

Clinical indications for residential care (reason cannot be treated in less restrictive environment). Please cite applicable ASAM placement criteria: _____

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Is the patient agreeable and motivated for treatment? ☐ Yes ☐ No

Current/Past Substances:

Primary:	Date Last Use:	Quantity:	Frequency:
Other:	Date Last Use:	Quantity:	Frequency:
Other:	Date Last Use:	Quantity:	Frequency:
Other:	Date Last Use:	Quantity:	Frequency:

Medical:

Medical conditions for which applicant is currently receiving care:_____

Past Medical Conditions: _____
Restrictions: _____
Allergies (Specify ex. Food allergy, peanuts; tree pollen):
_____

Currently Prescribed Medications:

Medication:	Dose:	Medical Condition:
Medication:	Dose:	Medical Condition:
Medication:	Dose:	Medical Condition:
Medication:	Dose:	Medical Condition:

Referring Provider Information:

Referred By:_____Title:_____

Phone Number:_____Email Address:_____

Agency Name and Address:_____

Contact information for referring provider (if different):_____

******Please Note******

Any specialty medical care needed while at Unity Healing Center that is not available as direct care through Cherokee Indian Hospital Authority MUST be funded through their home clinic Purchase and Referred Care.

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