Received

____ Provider One Checked
____ Added to Spreadsheet
____ Reviewed
____ Re-admit Checked

PLEASE FAX THIS TO:
ADMISSIONS – PIONEER CENTER NORTH
Fax: 360-856-3138

Pioneer Center North Referral Application Page

(Please fill this out as thoroughly as possible, even if the information can be found in the assessment)

NAME: ______ ______ ______
Last First Middle

AGE: ☐ **M** ☐ **F** ☐ **SS#** ☐☐☐ – ☐☐ – ☐☐☐☐ **DOB:** ☐☐ – ☐☐ – ☐☐

ADDRESS: ______

CITY: ______ **STATE:** ______ **ZIP:** ______ **PHONE:** ____ – ____ – ____

DISCHARGE HOUSING PLAN: ______

CONTINUING CARE AGENCY: ______

ETHNICITY: ☐ African Am. ☐ Asia/PI ☐ Caucasian ☐ Hispanic ☐ NA/AI/AK – TRIBE: ______

☐ OTHER – SPECIFY: ______

EMERGENCY CONTACT: ______ **RELATIONSHIP:** ______

PHONE: ____ – ____ – ____

REFERRING AGENCY: ______ **CONTACT PERSON:** ______

ADDRESS: ______ **PHONE:** ____ – ____ – ____

CITY: **STATE:** **ZIP:** **FAX:** ____ – ____ – ____

PROBATION/DOC DEPT: ______ **OFFICER:** ______

☐ Sex Offender Level: ☐ I ☐ II ☐ III **PHONE:** ____ – ____ – ____ **FAX:** ____ – ____ – ____

HISTORY OF SUICIDE ATTEMPTS, IDEATION, OR SELF HARM? ☐ **YES** ☐ **NO. IF YES, EXPLAIN**

HISTORY OF ASSAULT, ARSON, OR DOMESTIC VIOLENCE? ☐ **YES** ☐ **NO. IF YES, EXPLAIN**

MENTAL HEALTH CONDITIONS:

ANY HOSPITALIZATIONS IN THE LAST THREE MONTHS? ☐ **YES** ☐ **NO. IF YES, EXPLAIN**

MEDICAL CONDITIONS:

CURRENTLY ON MAT? ☐ **YES** ☐ **NO** **MAT PRESCRIBER:**

CURRENT MEDICATIONS:

PIONEER CENTER NORTH STAFF USE ONLY

ICD-10: ____ – ____ – ____ ☐ **I.V. DRUG USE** **COUNTY OF ORIGIN:** ______

CONTRACT: ______ **PROVIDER ONE #** ______ **INITIAL LENGTH OF STAY:** ______

PROGRAM: ☐ SUD ☐ NSCORP ☐ NSOUD **AUTH#** ______ **ASAM LEVEL:** ☐ 3.3 ☐ 3.5

☐ **APPROVED** ☐ **SEE COMMENTS** ☐ **READMIT YEAR:**

BED DATE: ______ ______ ______ ______ ______

REVIEWED BY: ______ **DATE:** ______

1960 THOMPSON DRIVE | SEDRO-WOOLLEY, WA 98284 | PHONE: 360.856.3186 | FAX: 360.856.3138
E-MAIL: pcnadmissions@p-h-s.com

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