North Country HEALTH CONSORTIUM

Friendship House
Residential Treatment Facility

CLIENT APPLICATION FOR ADMISSION TO FRIENDSHIP HOUSE

Please print, complete, and fax to (603) 869-2355. After sending, please call (603) 869-2210 to check that it was received.

Date:

Were you referred by someone (Provider, Emergency Room, Parole Officer, Attorney)? ☐ Yes ☐ No

If so, who?

Personal Information

Name: _____ DOB: _____

What gender do you identify with? Male ☐ Female ☐ Other ☐

Marital Status (single, married, widowed, separated or divorced): Widowed

Social Security #:_____

Address: _____

Phone Number (s):_____

Email: _____

Are you homeless? ☐ Yes ☐ No Are you a Veteran? ☐ Yes ☐ No

Preferred Drugs (s):_____Route: IV ☐ Yes ☐ No

Last use date/time:_____Age of 1st Use: _____

Have you been in treatment before? ☐ Yes ☐ No If so, where and when:

Alcohol Use: ☐ Beer ☐ Wine ☐ Liquor (type):

How often do you drink? ☐ Daily ☐ Every few days ☐ Every weekend ☐ Other:

How much do you drink? Last drink date/time:

History of seizures with withdrawal from alcohol? ☐ Yes ☐ No

Do you have medical insurance? ☐ Yes ☐ No

If yes: Name of insurance company _____

Group number_____ Member Number_____

Do you have an income at this point? ☐ Yes ☐ No

If yes, approximately how much to you earn? _____

Name of employer, if applicable: _____

Are you disabled? ☐ **Yes** ☐ **No** **If yes, Medical** ☐ **Psychiatric** ☐

Do you have children? ☐ **Yes** ☐ **No** **Gender and ages:** _____

If you have children, is DCYF involved? ☐ **Yes** ☐ **No** ☐ **N/A**

Legal Information

Do you have any current legal charges? ☐ **Yes** ☐ **No** **If yes, list court dates:** _____

Do you have any warrants in any state? ☐ **Yes** ☐ **No**

Have you been mandated to treatment? ☐ **Yes** ☐ **No**

If yes, who referred you? _____

Have you been arrested within the last 30 days? ☐ **Yes** ☐ **No**

Have you ever been charged with a sexual or violent crime? ☐ **Yes** ☐ **No**

Have you ever been charged with arson? ☐ **Yes** ☐ **No**

Do any of the following apply to you?

- **Probation/Parole?** ☐ **Yes** ☐ **No**
- **Bail?** ☐ **Yes** ☐ **No**
- **Restraining order?** ☐ **Yes** ☐ **No**
- **No contact order?** ☐ **Yes** ☐ **No**
- **Stalking order?** ☐ **Yes** ☐ **No**

Health Information

Do you have a PCP? ☐ **Yes** ☐ **No**

If yes, facility and provider name: _____

Do you have any major medical or mental health concerns? ☐ **Yes** ☐ **No**

If yes, what is your diagnosis? _____

Have you ever been diagnosed with schizophrenia or borderline personality disorder? ☐ **Yes** ☐ **No**

Do you have hallucinations? ☐ **Yes** ☐ **No**

Seizure disorder: ☐ **Yes** ☐ **No**

Do you have any communicable diseases? Check any of the following that apply to you:

MRSA ☐ **CDIF** ☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **Hepatitis C** ☐ **STDs** ☐

HIV/AIDS ☐ **Yes** **No**

TB Test Yes/No (circle one) **Positive Result** ☐ **Yes** ☐ **No**

If positive TB Test, did you have a chest x-ray? ☐ **Yes** ☐ **No**

Are you pregnant? ☐ **Yes** ☐ **No**

List any allergies or dietary restrictions here: _____

How many times have you been to the emergency room in the last 6 months? _____

What do you hope to get out of treatment? _____

Do you have proof of New Hampshire Residency? (NH Driver's License or NH photo ID)

☐ **Yes** ☐ **No**

Please list any current medications below (prescriptions, over-the-counter) : (Must provide a complete medication list signed by a licensed prescriber before an admission can be approved)

For Office Use Only-Please do not write below

Documents Needed	Needed?	Date Requested/Notes	Status
Proof of NH Residency	Y		
Signed Medication List including RX and OTC/Dietary Restrictions or Needs	Y		
Medical hx/medical notes			
Psychiatric hx/MH Notes			
Legal documents needed might include: • Letter from PO-non-violent/sexual offender • Restraining Order • No Contact Order • No Trespassing Order • No Stalking Order			
Other documents needed?			
Specific Releases needed?			

Urgent or critical needs:
Need further review by clinical for admission decision? ☐ **Yes** ☐ **No**
Date reviewed by clinical: _____
Date all pre-admission pw complete and decision made re: admission: _____
If approved, date/ time of first contact to schedule intake date: _____/_____ If not approved, resources/referral to: _____
If no bed available, date placed on waitlist/date intake provided: _____/_____
Date and time intake scheduled/completed: _____/_____

DOCUMENT ALL CONTACTS IN CONTACT LOG WITH FURTHER DETAILS

Contact Log

Date/time	Call made by?	Who was called?	Notes- (LM/ no answer/notes on call)