BRISTLECONE RECOVERY CENTER

WELCOME

Thank you for taking the first step in reaching out for help. Please take some time to complete the Referral Form so we can work towards identifying the services best fit for you.

April Lang-Barroga, LMFT, LCADC, NCC
Clinical Director

Please Submit Referral To:
admissions@bristleconereno.com
Fax: 775-954-1406

Bristlecone Recovery Center Referral Form:

Thank you for your interest in Bristlecone Recovery Center (BRC) for your treatment needs. BRC is named after the Bristlecone Pine Tree, a long-lived tree that is resilient to harsh weather and bad soils. This remarkable tree can fully regenerate itself, even on the brink of death. Just like the Bristlecone Pine, the people who seek help at our facility for addiction, gambling, and mental health issues have experienced negative environments, weathered many storms and come dangerously close to death. They have arrived at a pivotal point in their lives where they have determined they need and want treatment and counseling. They have always had the ability inside to regenerate. We simply provide the nurturing environment, proven treatments, and compassionate counseling to become strong, healthy and vibrant.

BRC offers comprehensive addiction, problem gambling, and mental wellness treatment services in Nevada. Bristlecone customizes treatment plans which then serve as a road map for clients in pursuit of a clean and healthy lifestyle for themselves and their families.

BRC offers a full continuum of treatment services including social model detoxification (with medical detox coming soon!), residential, transitional living, outpatient & intensive-outpatient, aftercare, targeted case management, treatment for co-occurring disorders and community education and outreach. Our staff puts extra effort into ensuring that clients have access to all of the resources available in our community. We don't compete with other agencies; instead, we focus on partnership to ensure that our community's addiction treatment needs are served.

Please Complete the following Screening Form thoroughly AND include prior clinical documentation (if applicable):

- ✓ Biopsychosocial or a Court Ordered Evaluation
- ✓ Psychiatric Evaluation
- ✓ Prescribed Medication List
  - To include dosage, frequency, physician prescribing.
- ✓ Court/CPS/PO/Legal Guardian Involvement:
  - Release of Information (ROI) is provided and will need to be completed and signed by the applicant.

Thank you for taking the time to put your wellness first and reach out.
We will be in touch soon.

Bristlecone Recovery Center Screening Form:

Today's Date:	
Name:	
Date of Birth:	
Phone:	
Address:	
E-mail:	
	Please Circle ALL Answers Below
Insurance:	NV Medicaid Commercial TriCare
	CA Medical Medicare None Other:
Sex:	Male Female
Sexual Orientation:	Heterosexual Homosexual Bisexual Other:
Preferred Pronouns:	He/Him She/Her They/Them
Fluent Languages:	English Spanish Other:
Seizure History:	Yes/Last Time: No
Pregnant:	Yes No Unsure
Problem Gambling:	
Do you gamble with any regularity?	
Yes No Only when using drugs and/or alcohol.	
Have you ever felt the need to bet more and more money? Yes No	
Have you ever had to lie to people, important to you, about how much you gambled? Yes No	

Please Respond to the Following Regarding Substance Use History:

Substance:	Last Use	First Age of Use	Current Use
1.			
2.			
3.			
4.			
Treatment History:	Program Name	Year	Status:(successful/ unsuccessful)
Outpatient			
IOP			
Residential			
Medical Detox			
Inpatient Psych			
ER/Medical Visit			
ER/Addiction Visits			

Please Circle which program(s) you are applying to:
Residential/Transitional Living/Problem Gambling
Intensive Outpatient/Outpatient

Primary Care Physician:	
Medical Diagnoses:	
Allergies:	
Contagious Diseases:	
HEP-C, TB, MRSA, HIV, COVID19	
Mental Health Diagnoses:	
Currently Prescribed Medication(s):	
MAT Medications (circle):	Methadone/Suboxone/ Subutex/Naltrexone/ Vivitrol

Mental Health Symptoms:	**Yes/No/Unsure**
Auditory Hallucinations	
Visual Hallucinations:	
Tactile Hallucinations:	
Delusions:	
Paranoia:	
Mood-Swings	
Depression	
Anxiety	
Binging/Purging/Restricting/ Excessive Exercise	
Self-Harm	Last Time:
Compulsive Lying	
Verbal Abuse	
Physical Abuse	
Sexual Abuse	
Harming Animals	
Harming Others	
Defiance/Opposition	
Vivid Nightmares or Flashbacks	
Suicidal Ideations	Last Time:
Suicide Attempt(s): When/How	

Authorization for Release of Client Information

Client Name: ____ **DOB:** _____________________________

This is to authorize the release of information regarding the above client.

Information to be released from: ____

____
Address City State Zip

____
Telephone

Information to be released to: Bristlecone Family Resources

704 Mill Street Reno, NV 89502
Address City State Zip

(775) 954-1400 Fax (775) 954-1406
Telephone

PURPOSE OF RELEASE: To disclose information between parties, for the assessment and treatment of gambling, alcohol and/or other drug addictions. This communication may reveal your presence in a treatment facility.

I AGREE TO DISCLOSE THE GAMBLING/ALCOHOL/DRUG/MENTAL HEALTH TREATMENT INFORMATION			
INITIALING:			
____	Client Diagnostic Assessment	____	Progress Notes
____	Intake Summary/Diagnostic Impressions	____	Non-Compliance Report
____	Treatment Plan	____	Referral Information
____	Urinalysis Results	____	Legal History Information
____	Status Report	____	Family History
____	Continuing Care Plan	____	Mental Health Assessment
____	Discharge Report	____	Other:

EXPIRATION OF CONSENT DATE: ____________________, or Condition/Event: 180 days after last client contact

Information for Informed Consent: The confidentiality of medical, psychiatric, and substance abuse information is protected by State and Federal statutes, rules, and regulations, including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These statutes, rules, and regulations require that the individual give informed consent prior to the release of and health and/or hospital records or information, except as specifically provided for within the statutes, rules, and regulations. Consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the signature of the individual/authorized representative and the date of the signature. The authorized representative signing for the client must present a copy of the legal document(s) that grants this authority. The authorization for the release of medical information waives any and all rights that the individual now has or in the future may have to bring legal action against the releasing person/facility/agency for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed "Authorization for the Release of Client Information". I understand I can revoke this permission in writing at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. The program cannot make signing this consent form a condition of treatment unless my treatment is required to satisfy an order from a court, another criminal justice agency, or is to be disclosed to a third party for payment, in which cases I may be denied treatment if I do not sign this consent form (per HIPAA, 1996). If you have questions, please contact our Privacy & Compliance Officer Linda Hammond at (775) 954-1400 ext: 102

SIGNATURE OF CLIENT:

____
Signature Date

____
Signature of Parent/Legal Guardian Date