# 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 Email or Fax 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<br>Other: | | |
| Sex: | Male Female | | |
| Sexual Orientation: | Heterosexual Homosexual<br>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 | | | |

| 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: _________________________

I authorize Bristlecone Family Resources to disclose/receive information to/from the following parties:

Please print:

| Name | Address | Relationship to client | Phone Number |
|---|---|---|---|
| | | | |

PURPOSE OF RELEASE: Care Coordination 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 understand that, by initialing the items below, all parties listed above are authorized by me to disclose/receive that information.***

| I AGREE TO DISCLOSE THE GAMBLING/ALCOHOL/DRUG/MENTAL HEALTH TREATMENT INFORMATION INDICATED BY CHECKING AND INITIALING THE FOLLOWING BOXES: | | | |
|---|---|---|---|
| ____ ☐ | 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

**NOTE:** 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 Admissions Team at (775) 954-1400 ext: 106

## SIGNATURES CERTIFYING APPROVAL FOR TWO-WAY RELEASE OF INFORMATION:

_______________________________________________________________

Signature Date

_______________________________________________________________

Signature of Parent/Guardian Date

_______________________________________________________________

Signature of Witness or Agent Authorized for Releasing Information Date

**NOTICE TO ORGANIZATION OR INDIVIDUAL RECEIVING INFORMATION**
**THE INFORMATION HAS BEEN DISCLOSED TO YOU FROM OUR RECORDS, THE CONFIDENTIALITY OF WHICH IS PROTECTED BY STATE AND FEDERAL LAWS.**
**YOU ARE PROHIBITED FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY THE LAWS AND REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS**