OUTPATIENT:
7595 Gallia Pike
Franklin Furnace, OH 45694
PH: (740)574-8000
RESIDENTIAL:
303/326 Gervais Road
Franklin Furnace, OH 45694
PH: (740)259-7000 FX: (740)259-7003

Preliminary Contact Sheet

Name: ____

DOB: __________________ SSN: __________________

Marital Status: __________________________________

Address: ______________________________________

____

County of Residence: ____________________________

___Own Home ___Other's Home ___Homeless

First Contact Date: _______________________________

Referral Source:_________________________________

Agency: ____

Agency Phone #: _________________________________

Personal Phone #:________________________________

3rd Party Phone #:_______________________________

Reason for Referral/Call: __________________________

COVID-19 Screening Questions:

Have you been in close contact with a confirmed case of COVID-19? ___ Yes ___ No

Are you currently or have experienced any of the following symptoms in the past 24 hours? ___ Yes ___ No

___Cough ___shortness of breath ___body aches ___loss sense of taste or smell ___vomiting ___diarrhea

Have you had a fever in the last 3 days? ___ Yes ___ No

Are you currently waiting for results from a COVID-19 test? ___ Yes ___ No

Drug Use History:

Primary Drug of Choice:	Age of First Use:	Yrs./Mths Used:	Date Last Used:	Amount used:	Frequency Used:
____________________	_____________	____________	_____________	__________	_____________

Secondary Drug of Choice:	Age of First Use:	Yrs./Mths Used:	Date Last Used:	Amount used:	Frequency Used:
____________________	_____________	____________	_____________	__________	_____________

Benzodiazepines: Misuse ever? ___ Yes ___ No Current Misuse? ___ Yes ___ No Last Use Date: _______ Amt: _____

Alcohol: Misuse ever? ___ Yes ___ No Current Misuse? ___ Yes ___ No Last Use Date: _______ Amt: _____

IV Use? ___ Yes ___ No If yes how long has client used intravenously? ________________

Medication Assisted Treatment? ___ Yes ___ No If YES, Start Date: _________ Agency: _______________________

Current Withdrawal Symptoms: ___ Yes ___ No

___ Sweating ___Rapid Pulse ___Nausea/Vomiting ___Diarrhea ___Shaking/Tremors ___Anxiety
___High Blood Pressure ___Agitation ___Fever ___Dizziness ___Hallucinations ___Insomnia
___Headache ___Seizures ___Confusion ___Muscle Cramps

Date of Last Substance Use: ____________ Substance used? ____________________

Detoxification Necessary? ___ Yes ___ No If Yes referral made to: ______________________________________

Legal History:

Active warrants? ___ Yes ___ No If yes out of what court? ________________ reason for warrant: ________________

CPS involvement with children ___ Yes ___ No If yes, what county is the case in? ______________________________

Court Involvement? ___ Yes ___ No If yes, what court? ______________________ Charge: ____________________

Currently on Probation? ___ Yes ___ No If yes, what department? ___________________ P.O. Name: _____________

List all criminal charges in Lifetime: ____

REV.12/23/2020(AB)

Current Medical Problems by Report:

___Epilepsy
If yes, medication prescribed for issue: ________________________ Dose: _____ Compliant? ___ Yes ___ No
___Cardiac Disease
If yes, medication prescribed for issue: ________________________ Dose: _____ Compliant? ___ Yes ___ No
___Chronic Pain where is the pain located? ___________________ what was the cause? ______________________
If yes, medication prescribed for issue: ________________________ Dose: _____ Compliant? ___ Yes ___ No
___Liver (type)_____/Kidney Damage
If yes, medication prescribed for issue: ________________________ Dose: _____ Compliant? ___ Yes ___ No
___AIDS/HIV or any other communicable disease: _____________
If yes, medication prescribed for issue: ________________________ Dose: _____ Compliant? ___ Yes ___ No
___Skin Lesions/eruptions located where? _________________ Symptoms: ________________________________
If yes, medication prescribed for issue: ________________________ Dose: _____ Compliant? ___ Yes ___ No
___Pregnant
If yes, what trimester? _____ high risk pregnancy? ___ Yes ___ No

Do you need to seek medical attention today? ___ Yes ___ No Reason: ____________________________________

Psychiatric Treatment History:

___None ___Intensive Outpatient Program ___Outpatient ___Partial Hospitalization Program
___Inpatient
___within past 12 mths
___2 or more admissions

Current Medications

Are you currently prescribed any psychotropic medication? ___ Yes ___ No Compliant? ___ Yes ___ No

Current psychotropic medications	Prescribed for what reason	Dosage	Frequency
________________________________	____________________	________	__________
________________________________	____________________	________	__________
________________________________	____________________	________	__________
________________________________	____________________	________	__________
________________________________	____________________	________	__________
________________________________	____________________	________	__________
________________________________	____________________	________	__________

Prescribing Provider: ___Psychiatrist ___PCP ___Other____

Prescriber Name: ____

Current Psychiatric Risk:

Suicidality: ___no ___Ideation ___Plan ___Means ___Prior Attempts
Homicidally: ___no ___Ideation ___Plan ___Means ___Prior Attempts

Client Signature: ______________________________________ Date: ____________________

Person Completing Form: ______________________________________ Date: ____________________

OFFICE USE ONLY:

Candidate for Placement ___ Yes ___ No Level of Care Recommended: ___Residential ___Outpatient ___Sober Living

Candidate placed on waitlist ___ Yes ___ No Date placed on list: __________ Reason on list: __________________

Were Interim Services Provided? ___ Yes ___ No Reason: ____

Date Assessment Offered: _______________Admitted ___No Show ___Other: ______________________________

Follow up to waitlist placement: Date Removed: ____________ Reason removed from waitlist: ____________________

Focus Residential Group, LLC
303/326 Gervais Road
7595 Gallia Pike
Franklin Furnace, OH 45629
Phone: 740.259.7000 Fax: 740.259.7003

Insurance Questionnaire

Name:____

D.O.B. __________________________________

S.S.# ___________________________________

1. Do you have Ohio Medicaid? Yes No
   If yes:
   a. Who is the managed care plan? __________________________________

2. If no to the above, have you applied for Ohio Medicaid Yes No
   If yes:
   a. When? ___________________________
   b. Who is your case worker? _______________________________________

3. Do you have Medicaid with another state? Yes No
   If yes:
   a. What state? ____________________________
   b. Date terminated _________________________
   c. Who was/is your Case worker? ____________________________________

4. Do you have other/commercial insurance? Yes No
   If yes:
   a. Which health plan? _____________________________
   b. Who is the guarantor? ___________________________
   c. Date terminated ________________________________

5. Do you have Medicare? Yes No
   If yes:
   a. Are you a qualified beneficiary? Yes No
   b. Are you on disability? Yes No
      If so, how much do you receive each month? _______________

"Changing Lives One at a Time"