Department of Corrections
WASHINGTON STATE

PIONEER HEALTH SERVICES
ADMISSION APPLICATION

Contact: David.Musser@doc.wa.gov

Name: _____ DOC number: _____

DEMOGRAPHY

Age: _____ Date of birth: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip code: _____

Homeless: ☐ Yes ☐ No Military veteran: ☐ Yes ☐ No VA benefits: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Transgender female ☐ Transgender male ☐ Other ☐ No answer

Race: ☐ White ☐ African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ American Indian/Alaskan Native ☐ More than one race ☐ Unknown ☐ Other ☐ No answer
Tribe/other (if applicable): _____

Hispanic/Latino: ☐ Yes ☐ No ☐ Unknown ☐ No answer

Emergency contact: _____ Relationship: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip code: _____

Referring agency: _____ Agent: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip code: _____

Person/resource involved in continuing care planning: _____

CURRENT LEGAL STATUS

Status: ☐ Petition for commitment filed per RCW 71.05 ☐ No commitment filed and meets RCW 71.05

Patient meets the commitment criteria, has a substance use disorder, and results in:
☐ A likelihood of serious harm,
☐ The patient being gravely disabled, or
☐ The patient being in need of assisted outpatient behavioral health treatment

Additional criteria:
☐ Two or more voluntary treatment, sober services, or detoxification admissions within the last 12 months

Was the patient informed about recommitment and extended stay? ☐ Yes ☐ No
Was the patient informed program is in a locked environment? ☐ Yes ☐ No
How do you expect the patient to respond to the environment? _____

History of high risk behavior (additional information may be required):
☐ None ☐ Arson ☐ Assault ☐ Domestic violence ☐ Homicide ☐ Sexual assault

Current/pending legal action: _____
Deferred sentence for treatment: _____

Parole/Probation Officer: _____
County: _____ Phone: _____

Name: _____ DOC number: _____

PHYSICAL HISTORY

Attach psychiatric or medical records for moderate and severe conditions

N/A - No symptoms
Mild - History of/mild symptoms present
Moderate - Frequent symptoms, causes moderate problems
Severe - Frequent symptoms, causes moderate problems

Condition	N/A	Mild	Moderate	Severe	Specific diagnosis and notes
Allergies	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	_____
Bipolar	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	_____
Cardiac	☐	☐	☐	☐	_____
Dental abscesses	☐	☐	☐	☐	_____
Depression	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____
Eating disorder	☐	☐	☐	☐	_____
Gastrointestinal bleeding	☐	☐	☐	☐	_____
Hepatitis A	☐	☐	☐	☐	_____
Hepatitis B	☐	☐	☐	☐	_____
Hepatitis C	☐	☐	☐	☐	_____
Hypertension	☐	☐	☐	☐	_____
Incontinence	☐	☐	☐	☐	_____
Malnutrition	☐	☐	☐	☐	_____
Non-ambulatory	☐	☐	☐	☐	_____
Pancreatitis	☐	☐	☐	☐	_____
Psychosis	☐	☐	☐	☐	_____
Respiratory	☐	☐	☐	☐	_____
Seizure	☐	☐	☐	☐	_____
Thyroid	☐	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	☐	_____
Ulcers	☐	☐	☐	☐	_____
Self-care inability	☐	☐	☐	☐	_____
Unable to self-feed	☐	☐	☐	☐	_____
Other	☐	☐	☐	☐	_____

Pregnant? ☐ Yes ☐ No Estimated due date: _____

Current prescribed medication(s): Attach additional information if necessary

Brand/Generic Name	Patient Use	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prescribing Physician (P.A./N.P.):
Name: _____ Phone: _____
Name: _____ Phone: _____

Name: _____ DOC number: _____

TREATMENT HISTORY

Admission date: _____ Location: _____ Discharge date: _____ Outcome: _____
Admission date: _____ Location: _____ Discharge date: _____ Outcome: _____

Frequency of hospitalizations within last 2 years (i.e., number of admits):

Substance use disorder inpatient …..... _____
Substance use disorder outpatient …….. _____
Convalescent/nursing home …… _____
Emergency room ……..... _____
Medical inpatient ……. _____
Psychiatric hospitalization …….. _____
State-approved subacute detox ……..... _____
State-approved acute detox ……... _____
Hospitalization detox ……... _____

Comments: _____

SUBSTANCE USE HISTORY

PST Code	Substance	Administration	Age of First Use	Frequency	Date of Last Use	Quantity Used
1						
2						
3						

Intravenous (IV) use? ☐ Yes ☐ No

Other substance(s) used: _____

Longest period of sobriety (specify if in a controlled environment): _____

_____ _____ _____
Prepared by Signature Date

_____
Position/Title

The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Distribution: **ORIGINAL** - Pioneer Health Services **COPY** - Referring Agency, Substance Abuse Recovery Unit Records