ADMISSION APPLICATION
Co-Occurring Intensive Inpatient Treatment
American Behavioral Health Systems

ABHS Fax: 509-242-1867 Email: doccdviolatortreatment@abhsinc.net

DEMOGRAPHICS:

NAME: _____ **DOB** _____
Last **First** **Middle**

AGE: **M** _____ **F** _____ **SS#:** _____ **DOC #:** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____ **PHONE** _____

HOMELESS: **YES** _____ **NO** _____

ETHNICITY: _____ African AM _____ Asia/PI _____ Caucasian _____ Hispanic _____ NA/AI/AK _____ Other

If Native American please list tribe: _____ OTHER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

Informed about possible extended stay: ☐ YES ☐ NO

HISTORY OF HIGH RISK BEHAVIOR: *(May require additional information)*

☐ None

_____

_____

_____

_____

☐ Arson

Please explain _____

_____

_____

NAME:_____

❑ Assault

Please explain _____

_____

_____

_____

❑ Homicide

Please explain _____

_____

_____

_____

❑ Sex Offense Level:_____

Please explain _____

_____

_____

_____

CURRENT CONVICTION: *(please specify)*

_____

_____

CCO:

NAME: _____ COUNTY: _____

PHONE:_____

NAME: _____

SUICIDE IDEATIONS/SUICIDE ATTEMPTS:

How Long Ago?

Any current ideations or plans?

What were the circumstances?

Was it planned?

When?

NAME:_____

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 significant problems

CONDITION	N/A	MILD	MOD	SEV	SPECIFIC DIAGNOSIS & ADDITIONAL NOTES:
Allergies (please specify)..	☐	☐	☐	☐	
Asthma.....	☐	☐	☐	☐	
Bipolar.....	☐	☐	☐	☐	
Cancer.....	☐	☐	☐	☐	
Cardiac.....	☐	☐	☐	☐	
Dental Abscesses.....	☐	☐	☐	☐	
Depression.....	☐	☐	☐	☐	
Diabetes.....	☐	☐	☐	☐	
Eating Disorder.....	☐	☐	☐	☐	
GI 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……	☐	☐	☐	☐	
Open Wounds……..	☐	☐	☐	☐	
Other……..	☐	☐	☐	☐	

MEDICAL HISTORY:

NAME OF MEDICATION(S) (***Current***)	DOSE	FREQUENCY

NAME OF MEDICATION(S) (***Past***)	DOSE	FREQUENCY

Mental Health Disorder Diagnosis (DSM) and Prognosis

Current Condition

Symptoms

Stability

Prior Treatment and Evaluations: (include Inpatient/ Outpatient/ Residential/ Day Treatment)

TREATMENT HISTORY:

Admission Date: **Discharge Date:** **Location:** **Discharge Outcome:**

FREQUENCY OF HOSPITALIZTIONS *(Within last 2 years)* **# of Admits**

TYPE

CHEMICAL DEPENDENCY INPATIENT …….

CHEMICAL DEPENDENCY OUTPATIENT …….

CONVALESCENT/NURSING HOME …….

NAME: _____

FREQUENCY OF HOSPITALIZTIONS *(Within last 2 years)*

TYPE	**# of Admits**
EMERGENCY ROOM …….	
MEDICAL INPATIENT …….	
PSYCHIATRIC HOSPITALIZATION …….	
STATE APPROVED SUBACUTE DETOX …….	
STATE APPROVED ACUTE DETOX …….	
HOSPITALIZATION DETOX …….	

NOTES: Other information that may be useful:

SUBSTANCE USE HISTORY:

PST CODE	S U B S T A N C E	ADMINISTRATION	FREQUENCY	DATE OF LAST USE	QUANTITY USED
1					
2					
3					

PREPARED BY _____ _____ _____

SIGNATURE TITLE DATE

ABHS STAFF ONLY

REVIEWED BY: _____ DATE: _____

RISK MANAGEMENT REVIEW BY: _____ DATE: _____

❑ A C C E P T ❑ D

RATIONALE _____