Please Complete this form in its entirely to be considered.
It can be returned to: awest@damascushouse1.org or 410.789.1987 (fax)

Date: _____

Person making referral: _____
Phone Number of referrer: _____

Consumer's Name: _____
SS#: _____ DOB: _____
Medical Assistance Number: _____

Picture ID: Yes / No

Methadone or Suboxone: Yes _____ mg No _____ Clinic:
Vivitrol Yes _____ No _____ _____

Drugs of Choice: 1. _____ Last Date of Use: _____
2 _____ Last Date of Use: _____
3 _____ Last Date of Use: _____

Probation/Parole (circle): YES or NO Agent: _____
Agent Phone: _____

Health Issues: _____

Can you climb Stairs? _____

Mental Health Issues: _____

PCP Name & Number: _____

Current Medications: Somatic: _____

Psycho-Tropic: _____

Current County of Residence: _____

Do you have housing set up for after treatment? _____

Do you have any relatives in treatment at the Damascus House, on the staff or on the Board of Directors? _____

Clinical Use:
Projected date of discharge: _____

Accepted: Yes or No
Reason for No: _____