

ST. CHRISTOPHER'S INN, INC.
PO BOX 150, ROUTE 9, GRAYMOOR
GARRISON, NEW YORK 10524-0150

ADMISSIONS
TELEPHONE: 845-335-1020
FAX: 845-424-4537

8:30 A.M. – 5:00 P.M.
MONDAY - FRIDAY

REFERRAL FORM

PLEASE COMPLETE ALL SECTIONS OF THIS FORM
INCOMPLETE FORMS CANNOT BE PROCESSED

NAME: _____

CONTACT NAME _____

ADDRESS _____

AGENCY NAME _____

County _____

TELEPHONE NUMBER _____

DOB _____

FAX NUMBER _____

SS# _____

MEDICAID NUMBER _____

Seq # _____

e-mail address: _____

INSURANCE DATA _____

ALLERGIES _____

MEDICAL HISTORY

PSYCHIATRIC HISTORY

SEIZURE HX YES _____ NO _____

ARE SEIZURES DRUG OR ETOH RELATED? YES _____ NO _____

EXPLANATION _____

CURRENT MEDICATIONS _____

CURRENT PSYCH MEDICATIONS _____

30 DAY SUPPLY MUST BE WITH PT _____

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If the client is taking any psychotropic medication or has a history of any psychiatric disorder a recent psychiatric evaluation should be faxed with Admission Form

PPD DATE _____ INDURATION _____

CHEST X-RAY DATE _____ RESULT _____

PROPHYLACTIC TX (IF ANY) _____

DATES OF TX _____

Include clients' most recent PPD reading in induration only. If there is a history of a positive PPD then a chest x-ray report must be included. PPD readings must be within six months and chest x-rays within one year.

CHEMICAL DEPENDENCY/DETOX INFORMATION

DRUG(S) OF CHOICE

LAST USE _____

PENDING APPOINTMENTS (LEGAL, DSS, MEDICAL, ETC.)

OTHER

ADDITIONAL INSTRUCTIONS

PLEASE FAX, HISTORY AND PHYSICAL, ROUTINE LAB WORK, CHEST X-RAY REPORT OR PPD IF AVAILABLE, WITH 2 PAGE REFERRAL FORM.

THERAPEUTIC BLOOD LEVELS ARE REQUIRED WHEN APPROPRIATE.

EX: DILANTIN, PHENOBARBITAL, TEGRETOL, DEPAKOTE

ALL BODY PIERCINGS MUST BE REMOVED PRIOR TO ADMISSION TO THE INN.

SIGNATURE

DATE

**If there are any further questions please call the Admissions Office at (845) 335-1020
Thank you for your cooperation.**