❑ New Consumer
❑ Previous Consumer

Knox / Licking Counties SAMI Treatment Program
Admission Referral Forms

Please complete the following and submit collaborative documents with the application. If unsure of information leave the area blank.

Client Name:_____ DOB: _____ Age: ____ SSN: _____

Address: _____ Phone: _____

City/Zip Code:_____

Payor Source:_____

Referral Source: _____ Person Making the Referral: _____

1. Resident of Knox/Licking County ❑ Yes ❑ No
2. SMD Diagnosis? Specify: _____
3. Substance Abuse/Dependency Diagnosis_____
4. Modified GAF Score Below 60? (Completed by SAMI Interviewer): _____
5. Have prior treatment interventions been unsuccessful? ❑ Yes ❑ No
6. In the last 12 months, has the consumer had multiple inpatient admissions, (hospital, detoxification, residential)? ❑ Yes ❑ No

Please list admissions for the last two years

Facility	Date of Treatment	Diagnosis

7. Has the client experienced difficulty maintaining Housing? ❑ Yes ❑ No
8. Has the client experienced involvement in the criminal justice system including arrests or probation/parole violations? ❑ Yes ❑ No

Probation/Parole Officer: _____

Please list incarcerations for the last 2 years:

Date In:	Date Out:	Location:	Offense:

9. Has the client required assistance with Activities of daily living? ❑ Yes ❑ No

_____ _____
Signature / Credential/ Title Date

❑ Additional Comments on the back side
Additional Comments: _____

_____

_____

_____

_____

Reviewed by SAMI Team: _____ (Date)

- ❑ Client admitted to SAMI Team on _____(Date)
- ❑ Client is eligible and was placed on a waiting list for admission to the SAMI team

  Interim Recommendations: _____

  _____

  _____

  _____

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  _____

- ❑ Client not admitted to SAMI team and referral source notified on _____ (Date)

(1) Reasons not admitted: _____

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_____

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_____

_____

(2) Recommendations: _____

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_____ _____

SAMI Team Leader Signature / Credentials Date