visit health recovery

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*Please email completed form to **prescreen@visithealth.com** and a staff member will get back to you shortly.*

# Adult Initial Placement Screen

Today's Date: / / *Month Day Year*

What service are you interested in?

☐ Intensive Outpatient Program ☐ Residential Treatment

☐ 1-on-1 Telehealth Session ☐ Other

**REFERRAL INFO** *Please fill out below section if you are referring another individual for treatment.*

Your Name: *First* *Last*

Relationship to Client: ◯ Self ◯ Spouse/Partner ◯ Family Member ◯ Professional Referral

Your Phone Number: Your Email Address:

*Is it OK to contact you?* ◯ Yes ◯ No

**CLIENT INFO** *Please fill out below section for the person seeking treatment.*

Client Name: *First* *Last* Gender: DOB:

Client Phone Number: *Is it OK to leave a voicemail?* ◯ Yes ◯ No

Client Email Address: *Is it OK to email?* ◯ Yes ◯ No

Client Home Address: *Street* *City* *State* *ZIP*

Describe the type of substances used:

Amount: Frequency: Date of last use:

Does the client have medicated assisted treatment? ◯ Yes ◯ No

Client's emergency contact name: *First* *Last*

Emergency Contact Number: *Is it OK to contact them?* ◯ Yes ◯ No

Emergency Contact Address: *Street* *City* *State* *ZIP*

Name of insurance provider: ID# Group#

*Is it OK to verify insurance?* ◯ Yes ◯ No

Do you agree to attend the next appointment? ◯ Yes ◯ No Appointment Date/Time:

How did you hear about our program?

Additional Comments?

***Client Signature:*** _____ ***Date:*** _____