REQUEST FOR ADMISSION (RFA)

Admission Department ~ Phone: 775-461-0025 ext. 115 | Fax: 775-461-0512 | Cell: 775-934-8537

email: intake@vitalityunlimited.ord

www.vitalityunlimited.org

Date: ______________________ Time: ____________

Applicant Name: ______________________ Phone Number: ____________

Caller Name: ______________________ Phone Number: ____________

Referral Source: ______________________
Agency

APPLICANT INFORMATION

Address: ______________________
PO Box or Street City State Zip

Email address: ______________________

SS#: ____ - ____ - ____ DOB: __________ Gender: ☐Male ☐Female

Primary Race: __________ Secondary Race: __________ Ethnicity: __________

Veteran: Yes No Are you homeless? Yes No If yes, how long? __________

Circle all that apply: Single Married Separated Divorced Widowed Live-In Partner

Employed F/T Employed P/T Self-Employed List Occupation: __________

Retired Disabled Student F/T Student P/T Homemaker

☐Inmate/Resident of Institution: List facility: __________

Source of Income: Employment Disability Unemployment Family/Friends Illegal gains

Highest Grade Completed: ☐ less than 8th grade ☐8-11th grade ☐12th/Diploma ☐GED ☐Vocational

☐Some college ☐Associates ☐Bachelors ☐Masters ☐Doctorate Area of Study: __________

Number of children younger than 18 in home: ______ Are you the primary care giver? ☐Yes ☐No

Name of Spouse/Partner: __________ Phone: __________

Emergency Contact: __________ Phone: __________

Relationship: __________

Type of health insurance: __________

Subscriber Number: __________

VITALITY UNLIMITED
VITALITY INTEGRATED PROGRAMS
COMPLETE BEHAVIORAL HEALTH

MEDICAL PAST AND PRESENT

Height: ____________ Weight: ______________ Last medical exam/Dr.'s appointment: ___________________

Currently Pregnant: Yes No Unknown If yes Due Date: _________________________

Are you currently receiving prenatal care? Yes No Last period?

How many times in the past 90 days have you been to the hospital for:

Substance Misuse: _________ Mental Health: ____________ Overdose: _________ Other: ____________

Do you have or have you had any of the following? (Please circle all that apply.)

Allergies	Yes	No	Heart Condition	Yes	No	Neurological Disorder	Yes	No
Cancer	Yes	No	Hepatitis A B or C	Yes	No	Open Sores/Wounds	Yes	No
COPD	Yes	No	High Blood Pressure	Yes	No	STD	Yes	No
Diabetes	Yes	No	Immune Disorder	Yes	No	Surgery	Yes	No
Epilepsy/Seizures	Yes	No	Liver Disease	Yes	No	Thyroid Disorder	Yes	No
Head Injury	Yes	No	Loss of Consciousness	Yes	No	Tuberculosis	Yes	No

MEDICATION

Please include *ALL* prescriptions, over the counter, and homeopathic remedies

Medication	Reason	Dosage	Dates

Are you capable of administering your own medication? Yes No

SPECIAL NEEDS

Do you have any disabilities? Yes No Explain: _____________________________

Do you have ambulatory issues? Yes No Explain: _____________________________

Do you require any of the following? (Circle all that apply) Wheelchair Walker Cain

Do you have any special learning needs? Yes No Explain: _____________________

Do you have hearing difficulty? Yes No Do you have a hearing aid? Yes No

Do you have speaking/communication difficulty: Yes No Explain: ____________________

Do you have reading difficulty or inability? Yes No Explain: ____________________

Do you have special spiritual or cultural needs? Yes No Explain: ____________________

LEGAL

Are you involved with the judicial/legal system now? Yes No Are you on Parole? Yes No

Are you on probation? Yes No Is treatment court ordered? Yes No

Please explain your current judicial/legal involvement: ____________________

____

Have you ever been charged with, arrested, or convicted of a violent crime? Yes No

Explain: ____________________

Have you ever been charged with, arrested, or convicted of a sex crime? Yes No

Explain:

EMOTIONAL

Do you think that you need treatment? Yes No

While clean and sober have you ever experienced seeing or hearing things that others said were not there?

Yes No If yes, explain: ____________________

Have you ever harmed yourself intentionally? Yes No If yes, explain: ____________________

____

Have you made suicide attempts? Yes No If yes, explain: ____________________

____

If yes, were you under the influence of drugs/alcohol at the time? Yes No

Have you ever thought of ending your life? Yes No If yes, explain: ____________________

____

Have you ever had mental health treatment? Yes No If yes, explain: ____________________

____

Are you have any current mental health problems? Yes No If yes, explain:

____

Do you have a current mental health diagnosis? Yes No What is the diagnosis?

____

Are you depressed at this time? Yes No If yes, explain: ____________________

____

Do you suffer from anxiety or panic attacks? Yes No If yes, explain: ____________________

SUBSTANCE USE PAST AND PRESENT

Have you ever taken Methadone or Suboxone? Yes No Legally or Illegally? ____________________

In what form? ________________________________ When was your last Methadone use? ______________

When was your last Suboxone use? ________________

OTHER SUBSTANCE USE – PLEASE LIST ALL

In the "Method of use Column," ***PLEASE*** *use the following numbers that apply to how you ingested the drugs. Example; alcohol as a drink is 1. Oral (by mouth) because you drink it.* ***ORAL=1, SMOKING=2, INHALATION=3, INJECTION/IV=4, OTHER=5***

SUBSTANCE	DATE OF LAST USE	AGE AT FIRST USE	# OF YEARS USED	AMOUNT	FREQUENCY	METHOD OF USE (1,2,3,4,5)
Alcohol						
Methamphetamines						
Cocaine						
Heroin/Opiates						
Marijuana						
Club Drugs						
Sedatives/Tranquilizers						
Prescription Medication						
Inhalants						
Tobacco						
Synthetic Drugs						

How old were you when you started using? ________________________________

What was the first substance/drug you used? ________________________________

What does drugs/drinking do for you? ________________________________

Have you ever injected drugs? Yes No

Did you increase the amount of the substance, so you could get the same effect? Yes No

Did you ever use more than one mood altering substance a day? Yes No

Have you ever stolen medication? Yes No Where from? ____________________

Do you have hangovers, headaches, are thirsty, agitated, or have upset stomach? Yes No

Do you have any physical effects when you do not use for a while? Yes No

Do you have any emotional effects when you do not use for a while? Yes No

Did your use of alcohol or drugs cause physical, medical or health problems? Yes No

Have you ever accidently overdosed? Yes No What happened? ______________________________

____

Did you use larger amounts of drugs or alcohol than you had planned or intended? Yes No

Did you use drugs or alcohol for a longer period than you planned or intended? Yes No

Have you ever done anything under the influence of alcohol and/or drugs that you would not do otherwise?

Yes No Explain: ____

Have you ever had DTs, hallucinations, or severe withdrawal? Yes No

What is the longest period you have ever gone without using/drinking? ______________________________

Were you in a controlled environment during this period of sobriety? Yes No

Were you ever arrested for a crime committed as a direct result of using or drinking? Yes No

Do you think that you need treatment for substance abuse? Yes No Why or Why not?

____

Do you gamble? Yes No Do you think you have a gambling problem? Yes No

INSURANCE / FINANCIAL

Primary

Name of Policy Holder: ______________________ SSN: ____________ DOB: __________

Group Number: __________________ Subscriber Number: ________________________

Secondary

Name of Policy Holder: ______________________ SSN: ____________ DOB: __________

Group Number: __________________ Subscriber Number: ________________

Name of Employer: ____________________________ Phone Number: ____________________

Employer Address: ____

Name of nearest relative not living with you: ______________________________

Primary Phone: ________________________ Cell Phone: ________________________

Address: ____

I, the undersigned, give permission to release information to third party carrier(s) and all insurance benefits for treatment are to be paid directly to VITALITY UNLIMITED and request that this assignment remain on file with my insurance carrier. I certify that this assignment shall be as valid as the original.

I, the undersigned, recognize that the provider cannot accept responsibility for collecting insurance claims or negotiating any settlement on a disputed claim. I also agree that in the event of a default in the payment of any amount due, or if this account is placed with an agency or attorney for collection or legal action, to pay any additional charge(s) i.e., the cost of collection including agency and attorney fees, and court costs incurred by laws governing these transactions.

____ ____________________

Client Signature Date

____ ____________________

Witness Signature Date

PLANNING FOR TREATMENT AT VITALITY

PLEASE LIMIT THE AMOUNT OF LUGGAGE YOU BRING TO TREATMENT

1. FREE your schedule of all obligations and appointments: Legal, Medical, Dental, CPS, Court, etc. You must take care of your pending issues PRIOR to entering treatment.

2. You will need two (2) forms of identification such as a driver's license, photo ID, Social Security Card or birth certificate.

3. If uninsured, you must have proof of household income for the past calendar year. Paycheck stubs, W2's, Tax Returns or a notarized letter from an acceptable agency.

4. **MEDICATION:** If you are taking prescribed medication it is your responsibility to provide them.
   - **BRING A FULL 30-DAY SUPPLY OF ALL APPROVED MEDICATIONS.**
   - Admission Coordinator must approve all medication during the application process.
   - If you have unauthorized medication in your possession upon admission, it will be destroyed.
   - HPN does not contract with Elko County pharmacies regardless of their other affiliation e.g., Raley's, Walmart, etc.
   - HPN Consumers must be prepared to pay for their medications.
   - All Consumers regardless of their payor source e.g., private or public health insurance will be charged for Blister Packs – a required method used to package your medication.

5. **CLOTHING:** Vitality Unlimited's dress code is strictly enforced, and anyone determined to be wearing clothing items determined by staff to be inappropriate will be confiscated by staff and returned at the time of discharge. Bring enough clothing and undergarments (socks, underwear, bras) for seven (7) days. Please do not overpack. We have laundry facilities.
   - Pants: NO holes or rips. Pants must fit properly! You will not be allowed to wear skintight or sagging pants.
   - Clothing that is considered provocative, gang related or otherwise overtly controversial are not allowed.
   - Certain clothing may not be suitable. Hooded shirts or sweatshirts are only allowed to be worn outside.
   - It is mandatory for Consumers to sleep in pajamas or sweatpants and t-shirts.
   - Slippers are need and a robe is suggested.
   - No open toed shoes.
   - Please be mindful of the time of year and bring seasonally appropriate items.

6. **HYGIENE PRODUCTS:** Read all product labels.
   - Products containing alcohol are not allowed.
   - Aerosols of any type (hairspray, foot spray, deodorants) are not allowed.
   - You should bring your personal toiletries: soap, toothbrush, toothpaste, deodorant, sunscreen, body lotion, shampoo, conditioner, hair dryer, curling iron, etc.

7. For journaling or writing letters bring non-wire bound notebooks/pads, stamps and envelopes.

8. All consumers will be charged $50.00 per trip for medical transport.

9. Consumers must purchase any vaping products from Vitality. Outside products are not allowed.

DO NOT BRING ITEMS OF VALUE. VITALITY UNLIMITED WILL NOT BE LIABLE FOR LOST OR STOLEN ITEMS. PLEASE LEAVE VALUABLES AT HOME.

PLEASE NOTE: Communication with family and friends will be restricted to written form for the first ten (10) days of treatment.

DO NOT BRING THE FOLLOWING ITEMS TO TREATMENT AT VITALITY

Alcohol
Illegal Drugs
Un-authorized prescriptions
Herbs
Vitamins
Tobacco replacement products
Commit lozenges
Nicotine patches
Vapes
Cigarettes
E-cigarettes
Vape Juice
Magazines or books
Cell Phones
Electronic games
iPods
CD/DVD Players
Laptops/notebooks/iPads
Television

Camera
Radio
Food
Beverages
Candy
Gum
Cough Drops
Electric toothbrushes
Electric razors
Perfume
Colognes
Nail polish or remover
Mouthwash
Latex/Nitril rubber gloves
Condoms
Bed linen/Sheets
Blankets/throws
Towels
Bicycles

Weapons
Guns
Knives
Sharp Objects
Tools
Scissors
Tattoo Guns or Paraphernalia
Ball Point Pens
Ink/Gel Pens
Markers
3 Ring Binders
Spiral Notebooks
Highlighters
Mechanical Pencils

Be aware that if any of the above-mentioned items are brought to Vitality, they will be removed immediately and/or may be destroyed.

Your signature indicates that you have been informed of the information on this form and agree to comply:

____ ________________________

Client Signature Date

____ ________________________

Witness Signature Date