NATIVE AMERICAN CONNECTIONS

Referral Intake Form

What services are you interested in receiving?* *(Please select all that apply)*

□AM IOP □PM IOP □ Residential Treatment □ Counseling Services □Youth Substance Use Program

□ Other: _____

*Please consult the attachment for more information on our services and ask the front office staff if you are interested a service you do not see listed above.

Referral Date: Referral Source:

First Name: **Middle Initial:** **Last Name:** **Alias/Nicknames:**

Date of Birth: **Social Security #:** **AHCCCS #:** □ N/A

Age: **Other Insurance/Provider #:** **Mothers Maiden Name:**

Home Address: □ Homeless

City: **State:** **Zip code:** □ I receive mail at this address

Phone #: ( ) **Contact Authorization:** *(Please select all that apply)* **Email:**

□ Phone Communication Allowed □ Mail Communication Allowed

Message #: ( ) □No Communication- If selected how can we contact you? @

Race: (Check all that apply) □ African-American □ Asian/Pacific Islander □ White □ Native American/Alaskan Native □ Native Hawaiian

Tribe Affiliation/Membership:

Ethnicity:□ Hispanic □ Non-Hispanic

□ **Pregnant-Due date:** **Primary Language:** **Preferred Language:**

Gender Identity: *(Ages 18 and up)* □ Gender Variant □ Intersex □ Man □ Transgender □ Woman □ Questioning □ Decline to Answer

Sexual Orientation: *(Ages 18 and up)* □ Asexual □ Bisexual □ Gay □ Heterosexual □ Lesbian □ Questioning □ Decline to Answer

Relationship Status:□Single □ Married □ Divorced □ Domestic Partnership □ Widowed **Military:**□ Active □ Veteran □ Disabled

□ **Open DCS Case** **Are you currently in NAC Housing?** □ yes □ no location?

Are you aware of any family members currently receiving treatment with NAC? □ Yes □ No If Yes, Who?

What needs/concerns led you to come in today?

IV Drug User

Any alcohol/drugs use □ Yes □ No **If yes, date of last use:** **Fentanyl Use** □ yes □ no □ Yes □ No

Any Legal Issues? **Registered Sex Offender:** □ Yes □ No **Probation/Parole:** □ Yes □ No **Court Ordered:** □ Yes □ No

Any current medication use: □ Yes □ No **Any Tobacco/Vaping use** □ Yes □ No

Do you have a primary care provider? □ Yes □ No **If yes, contact information:**

Any previous/current psychiatric or behavioral health services? □ Yes □ No **If yes, contact information:**

Parent/Legal Guardian Name (if applicable)**:** **Relationship:**

Address: **Phone #: ( )**

Emergency Contact Name: **Relationship:**

Address: **Phone #: ( )**

Are there any cultural *(spiritual, racial/ethnic, disability, dietary, gender identify, sexual orientation, nationality, tribal, gender preference)* **needs/preferences you would like to share with us?**

Language Assistance Needed: □ Yes □ No **Signature:**