NATIVE AMERICAN CONNECTIONS

Referral Intake Form

Referral Date: **Referral Time:** **Date:** ☐ **Adult** ☐ **Child**

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

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

Referral Source: **Other Insurance/Provider#:**

Home Address: ☐ *Homeless*

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

Phone #: ( ) **Contact Authorization:** *(Please select one)* **Email:**

☐All Communication Allowed ☐No Phone or Mail Communication

Message #: ( ) ☐No Mailing Communication ☐No Phone Communication **Facebook:**

Race: ☐ African-American ☐ Asian/Pacific Islander **Tribe Affiliation/Membership:**

(Check all that apply) ☐ Native American ☐ Native Hawaiian ☐ White **Tribal #:**

Ethnicity:☐ Hispanic ☐ Non-Hispanic **Primary Language:** **Preferred Language:**

Gender/Sex: **Gender Identity:**☐Gender Variant ☐Intersex ☐Man ☐Transgender ☐Woman ☐Questioning ☐Decline to Answer

☐Female ☐Male **Sexual Orientation:**☐Asexual ☐Bisexual ☐Gay ☐Heterosexual ☐Lesbian ☐Questioning ☐Decline to Answer

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

Children Status: ☐ No Children ☐ Children # of: ☐ Pregnant If pregnant, due date:

Highest Level of Education: **Employed:** ☐ Yes ☐ No **Monthly Gross Income:** ☐ N/A

Smoking Status: ☐Never ☐Current/Daily ☐Current/Some Days ☐Former Smoker ☐Smoker/Status Unknown ☐Unknown If Smoked

What needs/concerns led you to come in today?

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

Does the need/concern involve alcohol/drugs? ☐ Yes ☐ No **If yes, date of last use:** **Attended any support groups?** ☐ Yes ☐ No **IV Drug User** ☐ Yes ☐ No

Any Legal Issues? **Number of arrests in the last 30 days:** **Court Ordered:** ☐ Yes ☐ No

Any medication use in the last 6 months: ☐ Yes ☐ No **If yes, how many days are left?**

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 *(for example: spiritual, language, racial/ethnic, traditional, disability, dietary, gender identify, sexual orientation, nationality, tribal, gender preference practitioner)* **needs/preferences you would like to share with us?**

Language Assistance Need:☐ Yes ☐ No **Signature:**