Solutions House

41 Lakeview Dr. Douglas WY 82633 Phone (307) 358-2846 Fax (307)358-1144

For Office Use Only:
Date of first contact:_________________________ Date of screening:_____________________________
Date of Scheduled admission:_________________ Time of admission:____________________________
Referral agency or person:_____________________ Phone:_____________________________________
Method of arrival:____

Personal Information:

First name:_____________________________ Middle:___________ Last:___________________________

Sex: M or F Veteran: YES NO WY RESIDENT: YES NO

SSN:___________________________________ AGE:_________________ DOB:______________________

HOME ADDRESS:____

CITY:__________________________________STATE:____________________ZIP CODE:_______________

MARITAL STATUS: MARRIED_____ SINGLE_____DIVORCED_____SEPARATED______WIDOWED_______

CHILDREN: YES NO (IF YES LIST AGES:_____________ __________) PREGNANT: YES NO

CONTACT PERSON:_____________________________________RELATIONSHIP:______________________

PHONE NUMBER (S):____

CHEMICAL USE HISTORY:
Substances used on a regular basis:

Substance	Route of Administration	Date of last use

Residential History:

Facility Name	Date of attendance	Nature of Discharge

Psychological History:
Mental Health Diagnosis:

Diagnosis	Diagnosed By	Date if Diagnosis	Medications Prescribed

Legal History:

Do you have any active warrants out for your arrest? YES NO

Medical History:
Current medical conditions

Diagnosis	Diagnosed by	Date of Diagnosis	Medications prescribed

If taking medications, how do/will you pay for them?____
Have you been prescribed medications that you are not taking? YES NO

History of suicidal thoughts: Last 30 days: Lifetime: Attempts:

If yes, did you have a plan?____

History of Homicidal thoughts: Last 30 days: Lifetime: Attempts:

If yes, did you have a plan?____

Do you hear voices or see things other people don't see? YES NO

If yes, please describe:____

____

Physicians name, Facility, City:____

Date of last appointment?_________________________For:________________________________

Date of last physical:____

Date of last Hospitalization:_______________________________________For:________________________

Education and or Vocational

School	Dates attended	Degree or Certificate

Please include the following information with your application, if available:

- Admission information (if currently hospitalized or in residential treatment/facility)
- Psychosocial information or assessments
- Psychological testing
- Any medical information regarding ongoing treatments
- List of medications currently taking
- Progress notes (if hospitalized) or clinician notes from most recent counselor/psychiatrist/psychologist
- Level of Care recommendation (LOCUS)
- SSI/SSDI application status, if applicable
- Photocopy of all available identification
- Photocopy of proof of insurance/proof of income
- TB test results
- Guardian/Payee contact information
- Brief summary by the client describing what he/she hopes to gain by living at Solutions House

ADMISSION CRITERIA:

All persons admitted to the Solutions House shall have a mental illness and be at least 18 years of age or older. Solutions House does not discriminate against potential residents on the basis of race, creed, sex, religion, HIV status or sexual orientation.

COMMENTS (FOR OFFICE USE ONLY)

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