Drug Dependency Unit

2013 Treatment Schedule

(All applications for treatment must be submitted in entirety to be considered by review team & date) Applications will keep on file for no longer than 60 days.

Cycle 1

Review Date: 1-7-13----------Begin Date: 1/22/13---------End Date: 2/21/13

Cycle 2

Review Date: 2/19/13----------Begin Date: 3/4/13----------End Date: 4/4/13

Cycle 3

Review Date: 4/1/13----------Begin Date: 4/16/13---------End Date: 5/16/13

Cycle 4

Review Date: 5/13/13--------Begin Date: 5/28/13----------End Date: 6/27/13

Cycle 5

Review Date: 6/24/13----------Begin Date: 7/8/13----------End Date: 8/8/13

Cycle 6

Review Date: 8/5/13----------Begin Date: 8/19/13---------End Date: 9/19/13

Cycle 7

Review Date: 9/16/13---------Begin Date: 10/1/13-------End Date: 10/31/13

Cycle 8

Review Date: 9/28/13-------Begin Date: 11/12/13-------End Date: 12/12/13

Cycle 9

Review Date: 12/9/13-------Begin Date: 12/23/13---------End Date: 1/23/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICES

DDU
HIGHWAY 77/75
WINNEBAGO, NEBR 68071
402-878-2231 PHONE

ABERDEEN AREA DRUG DEPENDENCY UNIT'S RESIDENTIAL PRE-ADMISSION CRITERIA & GUIDELINES

1. Must be nineteen (19) years of age
2. American Indian/Alaskan Native or those eligible for direct service under I.H.S. guidelines (must provide proof of enrollment in a federally recognized tribe)
3. Must submit copies of two of the following, a social security card, marriage license, birth certificate, and state identification
4. There must be a signed release of information by the client included in the pre-admission packet for the DDU social worker to coordinate admission.
5. Results of a complete physical, TB skins test as negative, or if test results are historically positive, chest x-rays are negative and Isoniazid (INH) TB prevention medication documentation demonstrating medication completion as well as having been abstinent from any alcohol consumption during this period.
6. Must submit a current medication profile/list, if the client is on medication.
7. Alcohol/Drug withdrawal symptoms stabilized at least seven (7) days prior to admission.
8. Submit a complete history & physical thirty (30) days prior to review date for admission, and a history and physical update seven (7) days prior to admission. Any physical filled out by the client and not by physician will not be considered as part of the pre-admission process.
9. Ability to participate in some recreational activities and daily chores, however if his/her mobility is limited, will need a physician's statement indicating any mobility restrictions. Client must be ambulatory.
10. Must have written documentation that any medical, dental, and vision needs have been assessed, treated, stabilized prior to admission.
11. Clients must have results of a nutritional screening completed and attached with the admission packet.
12. A copy of any court order, mandatory commitment order, protective custody order, reporting requirements or other documents indicating specific terms or conditions imposed on the client while engaged in treatment. This includes copies of any signed releases of information forms for coordination of services.

13. Submit a chemical dependency evaluation/assessment completed by a licensed/certified counselor and valid within the past three (3) months and address any co-occurring issues. This assessment must indicate the clients global assessment of function level of (GAF) 50 and below; and specifies residential treatment. If the assessment/evaluation is older than three (3) months, it will need to be updated to reflect the current presenting problems. However, in the event that the client presents with a co-occurring disorder, there must be written documentation indicating stabilization prior to admission. Please note that the DDU is not equipped to address any psychiatric disorders and/or severely acute illnesses and therefore inappropriate for a referral who presents with these specific disorders.
14. Not be more than seven (7) months pregnant and must submit documentation of consistent prenatal care or cautions/limitations with the pregnancy while engaged in treatment.

Please note that all completed pre-admission applications will be reviewed on a first come basis and the review team will determine the eligibility and appropriateness for admission into the drug dependency unit. We thank you for your referral and look forward to conducting business with your agency and/or program.

Sincerely,

Barry Walker, BS, LADC, ICADC
Drug Dependency Unit Program Director

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DRUG DEPENDENCY UNIT'S ADMISSION CRITERIA & GUIDELINES

Items you may not bring

1. CD's, Tapes, MP3 Players, Headphones, Stereo, Radio's, CD players, IPods, Laptops, IPOD.
2. Cell Phones/Chargers/Pagers
3. Knives and other weapons
4. Wire hangers
5. Cameras
6. Candles
7. TV's, personal DVD players, DVD's/VHS movies
8. Heating Pads & extension cords
9. Food, Soda, and Pop
10. Wire Hangers
11. Magazines, pictures, photos that are sexually oriented or promote gang affiliation, alcohol & drug use, and/or gambling.
12. Caps, Bandannas, and hats (except for winter weather use)
13. Single razor blades
14. Energy or herbal supplements (including sports vitamins or energy supplements).
15. Outside medications and/or over the counter medications

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DRUG DEPENDENCY UNIT'S ADMISSION CRITERIA & GUIDELINES

Items you will be provided

1. Pillows
2. Blankets
3. Towels
4. Washcloths\
5. Shampoo
6. Razor for shaving
7. Conditioner
8. Laundry detergent & fabric softener

Please understand that all items brought into the drug dependency unit will be examined and inventoried as your property. Any items on the do not bring list will be confiscated, secured for you, and returned upon discharge unless item/s illegal to possess. Please bring your own skirts or shorts for sweat lodge, swimming trunks for the pool, and you will be required to buy your own postage stamps and calling phone cards

PRE-ADMISSION PHYSICAL EXAMINATION REQUIREMENTS

Aberdeen Area Drug Dependency Unit
Winnebago, Nebraska 68071

Visit Date: _____

Name: _____ Age: _____ DOB: _____ Sex: M___ F___
Address: _____ Zip: _____
Physician: _____ Allergies to Meds: _____

PHYSICAL FINDINGS:

(**Please attach Immunization Record**)

Height _____ Weight _____ BMI _____ Temp _____ Blood Pressure _____ Pulse _____ RR _____
Urinalysis _____ Hgb/Hct _____ BUN/Cr _____ Hem A1C _____

Vision Screening Report, if given: OD _____ OS _____ Bil. _____ With Correction: _____

Vaccines given today: DTP _____ Td _____ IPV _____ MMR _____ Varicella _____ Hep B _____
TdAP _____ Menomer _____ Gardisil _____ Influenza _____ Pneumovax _____ Other _____

PPD Placed on: _____ in body area: _____ **READ** on: _____ at _____ mm induration;
Therefore is: Neg(__) Pos(__); CXR on: _____ (__)Neg (__)Pos; Quantiferon Gold→_____ (__)Neg (__)Pos

Smoker: _____No _____Yes: # _____ cigs/day for _____ years / months / days. Quit attempts in past: #___ ___
Dental Exam: _____ **Food Allergy:** _____
Special Dietary Needs: _____

MEDICAL Exam	Normal	Abn.	Explanations
Appearance			
Eyes/ears/nose/throat			
Lymph nodes			
Heart (note murmur)			
Pulses (inc. Femoral)			
Lungs			
Abdomen/Pelvis			
Skin			
MUSCULOSKELETAL			
Neck			
Spine			
Shoulder/arm/forearm			
Elbow/wrist/hand			
Hip/thigh/knee			
Leg/ankle/foot			
Neurological			
Evidence of Scoliosis: No ____ Yes ____			Other:
Evidence of Hernia: No ____ Yes ____			
Stigmata of Marfan's Syndrome: No ___ Yes ___			

PHYSICIAN: _____ Signature: _____ Date: _____

HISTORY

*Explain "Yes" answers below: *(Significant findings/Chronic Health Problems, please review health history)*

		Yes	No
1.	Have you ever been hospitalized for any physical conditions?		
2.	Have you ever had major surgery?		
3.	Are you taking any pills or medicine?		
4.	Do you smoke or use drugs, or alcohol?		
5.	Do you have any allergies (meds, bees, etc.)		
6.	Have you ever passed out during or after exercise?		
7.	Have you ever been dizzy during or after exercise?		
8.	Have you ever had high blood pressure? Date of Last Exam:		
9.	Have you ever been told you have a heart murmur?		
10.	Have you ever had racing of your heart or skipped heartbeats?		
11.	Has anyone in your immediate family had serious medical conditions (i.e. Heart conditions, Diabetes, High Blood Pressure, Stroke, ect.) before age 50?		
12.	Do you have any skin allergies?		
13.	Have you ever had a head injury?		
14.	Have you ever been knocked out?		
15.	Have you ever had a seizure?		
16.	Have you ever had a stinger, burner or pinched nerve?		
17.	Have you ever had heat stroke or muscle cramps?		
18.	Have your ever been dizzy or passed out in the heat?		
19.	Do you have trouble breathing or do you cough during or after physical activity?		
20.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard)		
21.	Have you had any problems with your eyes?		
22.	Do you wear glasses or contacts?		
23.	Do you have any dental bridges or wear braces or a retainer? Dentures?		

Explanations for "Yes" answers:

Medications taken or Medication list attached: _____

WOMEN ONLY

Pregnancy History: _____ N/A : Do you think you might be pregnant now? _____Yes _____No: LMP: _____

How many pregnancies have you had? _____ Live Births: _____ Miscarriages: _____ Abortions _____

Did you have any complications with you pregnancies: _____No _____Yes→_____

Birth Control History:

What type of birth control are you using now? _____Pills _____Norplant _____IUD _____Tubal Ligation

_____Vasectomy _____Cervical Cap _____Foam/gel _____Diaphragm _____Natural Family Planning

_____Depo Provera _____Abstinence _____None

Social History

1. Substance Abuse History: _____

2. Mental Health History: _____

3. Nicotine Uses (Smoking/Chewing Tobacco): _____

Family History

Pertinent Medical Family History: _____

Pertinent Mental Health History: _____

ASSESSMENT and PLAN:

1. No _____ Yes _____ Patient is appropriate for a 30-day Alcohol & Drug Residential Treatment Program.
2. No _____ Yes _____ Patient can participate in Light exercise during this Treatment Program.
3. No _____ Yes _____ Patient should be placed on the following diet:

a. _____ Low Sodium	e. _____ 2200 kcal
b. _____ ADA	f. _____ Renal
c. _____ 1800 kcal	g. _____ Snacks x _____/ day
d. _____ 2000 kcal	h. _____ Other: _____

4. Dx.: _____
   Plan: _____
5. Dx.: _____
   Plan: _____

PHYSICIAN: _____ Signature: _____ Date: _____

Admission Provider Review: Date: _____

_____ Yes: Patient is appropriate for our DDU Program.

_____ Yes: Patient is appropriate for our DDU Program with the following cautions/restrictions:

i. _____

ii. _____

_____ No: Patient is NOT appropriate for our DDU Program.

_____ Other: _____

Provider: _____ Signature: _____ Date: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Drug Dependency Unit Release of Information

I, _____, hereby voluntarily authorize the disclosure of my substance abuse treatment records
(Name of Patient)

The substance abuse treatment information is to be disclosed by:
Name of Facility

_____
Address

_____
City/State

_____

And is to be provided to:
Name of Facility

_____
Address

_____
City/State

_____

The purpose of this disclosure is: (Initial)

_____ Further Medical Care _____ Attorney _____ After Care _____ Research

_____ Personal Use _____ Insurance _____ Disability

_____ Other: (Specify _____

The substance abuse treatment record information to be disclosed is: (Initial)

_____ Only information related to: _____

_____ Only the period of events from: _____

_____ Other (specify) CHS, Billing, etc.: _____

_____ Intake Assessment's: _____

_____ Discharge Summary: _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: (Initial)

_____ Expiration Date, Event or Condition: _____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or other healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____ Patent Signature: _____

Signature of person signing form if not the patient: _____
(Describe authority to sign on behalf of patient)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

PATIENT REGISTRATION
PHS Indian Hospital
Winnebago, NE 68071

Chart Number: _____

NAME: _____ Maiden Name: _____
First Middle Last

Sex: _____ Date of Birth: _____ SSN: _____ Marital Status: _____

Mailing Address: _____

City/State/Zip: _____

Birthplace (Town/State): _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Tribe of Enrollment: _____

Tribal Enrollment Num: _____

Tribal Blood Quantum: _____

Indian Blood Quantum: _____

Religion: _____

(Please Circle the following)

Veteran: NO YES If YES Branch: _____ Entry: _____ Separation: _____ Vietnam: NO YES

Medicare: NO YES If YES, State Number: _____

Medicaid/KIDS CONNECTION: NO YES If YES, State Number: _____

Private Insurance Coverage: NO YES If YES, Policy Number: _____

(Please give your Medical Card to Hospital Personnel to make a copy for your records)

Employer Name and Address: _____

Spouse's Employer Name and Address: _____

Father's Name: _____ Tribe: _____ Birth Place: _____

Mother's Name (Maiden): _____ Tribe: _____ Birth Place: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone #: ( ) _____

City/State/Zip: _____

Next of Kin: (Other than Emergency Contact)

Name: _____ Relationship: _____

Address: _____ Phone #: ( ) _____

City/State/Zip: _____

**I certify that the information contained herein is true to the best of my knowledge and authorize my Tribal Agency to release my enrollment number to the PHS Indian Hospital, Winnebago, NE 68071

_____ _____
Patient/Guardian Signature Date

Pre-Admission Application
For
Residential Behavior Health Services

Today's Date:_____

I. GENERAL INFORMATION

NAME – PLEASE PRINT

LAST:_____ FIRST:_____ MI_____

SOCIAL SECURITY NUMBER

_____

CURRENT ADDRESS

Address: _____

City: _____ State: _____ Zip_____

Present Living Arrangements: I currently live_____

PHONE NUMBERS

Work (____) _____

Home (____) _____

Cell (____) _____

Tribe	Enrollment #	Degree of Blood	DOB:_____ Current Age:_____

Sex	Height / Weight	Marital Status	Dependents
Male____ Female____	Height _____ Weight_____	Single_____ Married_____ Divorced_____	

Source of Income	Medical Insurance

EMERGENCY CONTACT

Name: _____ Phone: (____) _____ Relationship to you_____

Address: _____ City: _____ State:_____ Zip:_____

II. REASON FOR REFERRAL

Who suggested or is requiring you to seek treatment? Their name:_____

Address:_____ City:_____ State:_____ Zip:_____

Why?_____

_____

III. OTHER CONTACT INFORMATION

Attorney Name:_____ Phone# :_____

Address: _____ City: _____ State:_____ Zip: _____

Probation or Parole Officer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

IV. MILITARY EXPERIENCE

Are you a veteran? _____ Yes _____ No If yes, were you involved in active duty? _____ Yes _____ No

Type of Discharge Received: _____

V. EDUCATIONAL EXPERIENCE

CIRCLE HIGHEST GRADE COMPLETED

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Degree _____

Have you had additional training or technical education? _____ Yes _____ No If yes, what kind?

VI. LEGAL HISTORY

List legal problems/charges that are the direct result of alcohol and /or drugs that you have experienced:

Have you been charged with driving under the influence? _____ Yes _____ No How many times were you charged with this offense? _____

Is there a legal action of any kind pending against you at the present time? _____ Yes _____ No If yes, Explain: _____

VII. MEDICAL HISTORY

Are you presently under a doctor's care? _____ Yes _____ No

If yes, for what condition? _____

Are you currently on any prescribed medication of any kind? _____ Yes _____ No If yes, please specifically list each medication you are on: _____

Physician's Name: _____

Hospital or Clinic: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

List current/past medical problems: _____

Do you have allergies? _____ Yes _____ No If yes, please explain: _____

Do you have: Diabetes Type I _____ Type II _____ Controlled_____ Uncontrolled _____ No Diabetes _____

Do you have any Special Dietary Needs because of a health condition? _____ Yes _____No

If yes, please explain: _____

_____

Have you ever been diagnosed with HIV/AIDS? _____ Yes _____No

Have you ever been diagnosed with Hepatitis B? _____ Yes _____No

Have you ever been diagnosed with Hepatitis C? _____Yes _____ No

Have you ever been diagnosed with Tuberculosis? _____Yes _____ No

Have you ever been told you have Fetal Alcohol Syndrome or Fetal Alcohol Effects? ____Yes ____No

Have you ever received Tobacco Cessation classes? _____Yes _____No If yes,. Were you successful at stopping tobacco use? _____Yes _____No

VIII. PSYCHIATRIC / PSYCHOLOGICAL INFORMATION

Are you presently or have you recently been thinking or suicide? ___ Yes ___ No If yes, explain:

_____

_____

_____

Have you ever heard voices saw things that other people do not see or hear? ___ Yes ___ No

If yes, were these experiences a result of alcohol / drug usage or during withdrawal? Please explain:

_____

_____

Have you seen a counselor, psychiatrist or other professional person for mental or emotional difficulties? ____ Yes ____ No If yes, please give dates and describe details: _____

_____

Have you ever experienced depression or anxiety or received some other diagnosis such as bipolar, depression, Anxiety, schizophrenia, etc. ____ Yes ____ No If yes, please explain _____

_____

Have you ever been on medication for any of these conditions? ____ Yes ____No If yes, please give the following

MEDICATION DATE DURATION REASON NAME OF PRESCRIBING DOCTOR

_____

_____

_____

How would you describe your anger? ____ I don't feel angry ____ I feel angry ____ I am angry most of the time

_____ I am so angry and hostile all of the time that I can't stand it

Tell us more about your anger _____

_____

_____

Have you ever been a victim or a perpetrator of domestic violence? _____Yes ____No

Please Explain: _____

_____

_____

If you answer yes to above question, have you ever received victim counseling? _____Yes ____ No.

Have you ever been emotionally, sexually, or physically abused? ____ Yes ____ No. If yes, please briefly describe

_____

_____

_____

SUBSTANCE ABUSE HISTORY

Please answer the following questions. Have you ever . . .

____Yes ____ No 1. Tried to cut-down on your use of alcohol / drugs?

_____Yes ____ No 2. Felt annoyed by someone talking to you about your alcohol or drug use?

____ Yes ____ No 3. Felt guilty about your drinking or drug use?

_____Yes ____ No 4. Drank shortly after waking up (eye-opener)?

____ Yes ____ No 5. Experienced a blackout?

_____Yes ____ No 6. Are you currently receiving counseling for substance abuse?

What areas of your life have been affected by your use of alcohol or drugs? (Check all that apply)

____ Education	____ Legal
____ Employment	____Recreational
____ Family	____ Social
____ Financial	____ Spiritual
____ Health	____Other: _____

Are there other members of your family who have problems with alcohol/drugs? ____ Yes ____ No If yes, explain:

_____

_____

_____

What influenced you to use alcohol / drugs? _____

_____

_____

How would you describe your use of alcohol / drugs? _____

_____

_____

What periods in your life have you used the most? _____

_____

_____

What is your favorite substance to use? _____

Have you ever over-dosed? ____ Yes ____ No

Were you ever admitted for detox services? ____Yes ____ No If yes, how many times? _____

Do you believe that you have a problem with alcohol/drugs? ____ Yes ____No

Have you ever been treated for chemical dependency before? _____Yes _____ No If yes, ____# times

How many times did you complete treatment? ____

What type of program did you enter? ____ Outpatient _____ Residential ____ Hospital-based program

____Other: _____

How long were you abstinent from alcohol / drugs? _____ What helped you to maintain sobriety? _____

What do you believe caused you to start using again? _____

_____

List your most recent treatment experiences:

Names of Treatment Program	Mo/Yr	Completed?	Days Sober?
1. _____	/_____	Yes__No	_____
2. _____	/_____	Yes__No	_____
3. _____	/_____	Yes__No	_____

PATTERN OF USE

SUBSTANCE	HOW USED	HOW MUCH	HOW OFTEN	Age Started	Age Stopped
Gas, Paint, etc.	Inhale				
Nicotine	Smoke				
Caffeine	Oral				
Beer	Drink				
Wine	Drink				
Liquor	Drink				
Lysol	Drink				
Amphetamine/Crank	IV/Oral/Snort				
Barbiturates	IV/Oral/Snort				
Methaqualone	IV/Oral/Snort				
Tranquilizer	IV/Oral				
PCP	Oral/Smoke				
Cocaine	IV/Oral/Smoke				
Marijuana/Hash	Smoke/Oral				
LSD	IV/Oral				
Mescaline	IV/Oral/Smoke				
Psilocybin	IV/Oral				
Opium/Heroin/Morphine	IV/Oral/Smoke				
Prescription Drugs	IV/Oral/Smoke				
Other Substances	IV/Oral/Inhale				

APPLICANT'S SIGNATURE

_____

DATE

_____

THIS SECTION TO BE COMPLETED BY REFERRAL SOURCE

Referring Source: Caseworker, Counselor, Spouse or other Person(s) who have knowledge of the applicant.

How long have you worked with this individual before the referral?

Briefly describe this person's physical, emotional and mental state.

DSM-IVR Information: (If available)

How would you describe their motivation for treatment?

What areas of life or particular problems do you feel this individual needs to work on while in treatment?

Have tentative aftercare plans been made for this individual? ____ Yes ____ No If yes, please describe.

_____

_____

_____

_____

_____

If the client is court-ordered to treatment, please provide us with a copy of the legal documents. Also briefly describe the situation including any pending court dates, or required visits by the Probation/Parole Office.

_____

_____

_____

Is there any other significant information that we need to be aware of regarding this referral?

_____

_____

_____

Name of Referring Agency: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone (_____)_____