Hartford HealthCare

The Ridge Recovery Center

PHONE: 860-465-3480 **FAX:** 860-392-5684
EMAIL: ridgeadmissions@hhchealth.org

Thank you for your interest in The Ridge Intensive Inpatient Program. We want to be sure our program will meet all of your client's needs.

You will receive an initial update with their status to the contact information provided once preliminary review is completed.
Our preferred form of communication is email, if you could provide yours that would be best.

Please keep in mind the following information regarding our program:

- We are a 3.7 level of care program.
- Clients must have a **primary** substance abuse diagnosis.
- Client's must be medically stable and independent with ADLS.
- Client's must have a qualifying medical and/ or mental health diagnosis and meet ASAM Criteria for a 3.7 level of care.

Please submit the requested documents below.

☐Biopsychosocial and/or psychiatric evaluation
☐History and physical
☐All nursing and progress notes from the past 3 days
☐List of current medications
☐TB screen – PPD, CXR, or Quantiferon
☐Recent laboratory work
☐Face sheet/Demographics, and insurance information.

Referring Location:

Referral Contact Name

Referral Phone:

Referral Email:

Anticipated Discharge Date:

Client name:

DOB:

Insurance Plan:

Subscriber ID#:

Group ID#:

Substance Use

SUBSTANCE NAME (*type if not listed)*	**METHOD OF USE, AMOUNT, DURATION**

Mental Health History

Diagnosis: 1. **2.** **3.**

Is the client's MH currently stable? If no, please provide details.

Is the client medication/treatment compliant?	☐YES ☐NO
Does the client have active hallucinations?	☐YES ☐NO
Has the client had a suicide attempt in the last month or frequent suicide attempts in the last year?	☐YES ☐NO

Is the client participating in groups?	☐YES ☐NO
Any loss of impulse controls that result in property damage or destructive behaviors or violence towards staff or peers?	☐YES ☐NO
Is the client willing to partake in Mental health assessments and Medication if needed?	☐YES ☐NO

Medical History

Diagnosis: 1. **2.** **3.**

Is the client currently medically stable? If not, please provide details:

Does the client require frequent medical follow up and/or appointments?	☐YES ☐NO
Is the client on prescribed suboxone or any controlled substances?	☐YES ☐NO
Does the client require the use of CPAP, oxygen, etc.?	☐YES ☐NO

Does the client need wound care?	☐YES ☐NO
Is the client on methadone maintenance?	☐YES ☐NO
Can the client ambulate independently and complete ADLs independently?	☐YES ☐NO