Neighborhood Properties, Inc.
The Wellness and Recovery Center
2619 Glendale Ave. Toledo, OH 43614
FAX 419-473-9706

REFERRING PROVIDER SECTION

The Wellness and Recovery Center offers 24 hour respite and support by trained Peer Specialists (staff in recovery with lived experience of mental health or substance abuse conditions). Spending time at the Center should be the guest's own personal decision. Guests must be:

- over the age of 18
- referred by a service provider
- able to take medications independently
- have a permanent residence to go return to in Lucas County
- experiencing emotional distress or a need for additional support

Guests must NOT be in crisis, medically compromised, or actively using drugs or alcohol during their stay.

The WRC maintains a sober environment.

1. Name of prospective guest: _____

2. Please indicate the reason for respite at the Wellness and Recovery Center:

_____

_____

_____

The person being referred:	**Yes**	**No**
Is a resident of Lucas County?		
Is 18 years or older?		
Is a voluntary enrollee (Individual must choose to participate in WRC services)?		
Is in stable physical health which includes not needing inpatient detoxification services?		
Has the ability to manage his/her own medication independently, if he/she chooses to take medications (Medications are not dispensed at the WRC)?		
Is experiencing emotional/ mental health distress?		
Has a permanent place to return to at the time of checking out from the WRC?		
Is at imminent risk of serious harm to self or others?		
Has had suicidal ideations within the past 30 days?		
Has a history of violence within the last 30 days (Individuals with a history of violence within the last 30 days will still be considered on a case-by-case basis)?		

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Persons being referred to the WRC have a psychiatric diagnosis of serious mental illness or present signs and symptoms that are consistent with a possible serious mental illness. If the perspective guest has been formally diagnosed please indicate diagnosis:

_____

_____

Specify any known drug and/or alcohol disorder: _____

If so, approximate last day of usage: _____

Has a diagnosis of dementia, organic brain disorder or traumatic brain injury (TBI)? _____

If so, explain: _____

Date of Referral: _____

Referring Provider Agency Name: _____

Referring Provider Agency Program Name: _____

Print Referring Provider Staff Name: _____

Signature of Referring Provider Staff: _____

Phone: _____ Fax: _____

Email: _____

NOTE: Any additional documents (such as psychosocial or psychiatric evaluations) may be sent with this form and are appreciated. Thank you for your referral.

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PROSPECTIVE GUEST SECTION

Name

Suffix | **Preferred/Alias**

Permanent Address | **City, State** | **Zip Code**

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐☐☐
month *day* *year*

Ethnicity
- ☐ Non-Hispanic/Non-Latino
- ☐ Hispanic/Latino

Veteran Status
- ☐ Yes
- ☐ No

MACSIS #

Race: Check all that apply
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Island Pacific Islander
- ☐ White

Gender Identify With
- ☐ Female
- ☐ Male
- ☐ Gender Non-Conforming

Primary Language:

Interpreter Services Needed?

Marital Status
- ☐ Single
- ☐ Married
- ☐ Committed Relationship
- ☐ Separated
- ☐ Divorced
- ☐ Spouse/Partner Deceased

Current Living Situation
- ☐ By myself
- ☐ With a roommate
- ☐ With parents or relatives
- ☐ With with spouse/significant other
- ☐ With my child/children

How were you referred to the Wellness and Recovery Center
- ☐ Self referred to the WRC
- ☐ Mental Health Agency
- ☐ Physician referral
- ☐ Other _____

Medical and Allergy Information

Chronic Health Conditions	Allergies + Reactions

I understand that my stay at the Wellness and Recovery Center is voluntary and that I am not in crisis, medically compromised, and will not use drugs or alcohol during my stay.

_____ _____
Print Name of Prospective Guest ***Signature of Prospective Guest***

_____ _____
Date ***Phone #***