

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
- 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: _____ MACSIS # _____

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 current address 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)? | | |



Neighborhood Properties, Inc.
The Wellness and Recovery Center
2619 Glendale Ave. Toledo, OH 43614
Phone 419-473-2604 ext. 157
Fax 1-440-427-3037



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 primary 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: _____

In an effort to reduce the risk of COVID-19 exposure to the Wellness and Recovery Center staff and guests, the following questions must be answered on behalf of all prospective guests.

Has the prospective guest had a recent hospitalization within the last 30 days? Yes ___ No ___

Has the prospective guest had recent social contact with persons presumed COVID-19 positive? Yes ___ No ___

Does the prospective guest have a current temperature below 100.4 degrees Fahrenheit? Yes ___ No ___

Is the prospective guest vaccinated? Yes ___ No ___

Date of Referral: _____ Self Referral? Yes ___ No ___

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

Current Address **City, State** **Zip Code**

Social Security Number

| | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|
| | | | - | | | - | | | | |
|--|--|--|---|--|--|---|--|--|--|--|

Date of Birth

| | | | | | | | | | | |
|--------------|--|---|------------|--|---|-------------|--|--|--|--|
| | | / | | | / | | | | | |
| <i>month</i> | | | <i>day</i> | | | <i>year</i> | | | | |

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 spouse/significant other

With my child/children

Street/Shelter

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 #