

Addiction Directions

Participant's Info for Initial ADAP Consult

1. Name: _____ Phone: _____

2. Dob: _____ Sober date: _____ D/C date: _____

3. Living Environment at Transition: _____

4. Address: _____

5. E-Mail: _____

6. Provide copy of final Continuing Care Plan, Discharge Plan.

7. Rehab History:

Type: Facility Name: Length of Stay: When: D/C Status:

Res / IOP _____

Res / IOP _____

Res / IOP _____

Res / IOP _____

Res / IOP _____

Res / IOP _____

8. Drug of No Choice: _____

Primary

Secondary

Tertiary

9. Legal Issues: Yes ___ No ___ What: _____

10. Medical Issues: Yes ___ No: ___ What: _____

11. Medications: Dosage: Refills:

12. Road Blocks to Recovery: _____

13. Successes at Rehab:

14. Struggles at Rehab:

15. Participant's Strengths:

16. Participant's Weaknesses:

17. Collateral Contacts:

Name: _____ Relationship: _____

Address: _____

E-Mail: _____

Phone: Home: _____ Cell: _____

Work: _____ Fax: _____

Name: _____ Relationship: _____

Address: _____

E-Mail: _____

Phone: Home: _____ Cell: _____

Work: _____ Fax: _____

Name: _____ Relationship: _____

Address: _____

E-Mail: _____

Phone: Home: _____ Cell: _____

Work: _____ Fax: _____

Please attach additional pages if needed.

Name: _____ Relationship: _____
Address: _____
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Work: _____ Fax: _____

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