



Institute for Health and Recovery

Norma Finkelstein, Ph.D., Executive Director

349 Broadway Cambridge, MA 02139 (617) 661-3991 Fax (617) 661-7277 TTY (617) 661-9051 www.healthrecovery.org

Pegasus House 16-19 Year Old Female Referrals

Pre-Admission Checklist

The following is a checklist of items that must be complete before a youth/young adult can begin treatment. Without the items from Section 1 completed at the time of intake you will not be admitted to the treatment program. Central Intake Care Coordination staff can answer questions and help families complete these items.

**Call CICC to provide the following information:
617-661-3991 or toll-free at 866-705-2807**

Section 1: Information needed for referral

- Referral Source: _____
(Name & Position)
- Name, Age & DOB of Client: _____
- CICC Staff Person Contacted: _____
Date & Time: _____
- Emergency Contact: _____
- Release of Information for IHR/CICC to contact collaterals
- Bio-Psychosocial Assessment
- Current medications _____

- Review BSAS Cost Share Policy

Section 2: Information Needed at Intake

- Face sheet with all demographic information
- Treatment Plan from referring source
- Physical within the past year
- List of all Collaterals Contacts & Contact Information
- Social Security card
- Health insurance card(s) (front and back)
- A 30-day supply of each medication; refills and blister packs are preferred
- For DCF/DYS clients, Working Together Agreement

Massachusetts Adolescent Residential Substance Abuse Treatment

CAB Adolescent Danvers, Boys Highland Grace House Worcester, Girls Pegasus Lawrence, Girls Phoenix Academy Springfield, Boys Project Rebound Quincy

Consent for the Release of Information

I, _____, hereby authorize (initial next to all that apply):

- CAB Adolescent
- Grace House
- Pegasus
- Phoenix Academy
- Project Rebound

To communicate with the Institute for Health and Recovery and the Massachusetts Department of Public Health in order to facilitate the delivery of appropriate treatment services to me and to enable the Residential Program to report on my progress. The extent of the information to be disclosed is information obtained by the Residential Program during its substance abuse screening, my client status (e.g. active, program completed, left against clinical advice), attendance information, and progress information, including level of participation and urinalysis results.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Pt. 2m and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Pts. 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows: ONE YEAR AFTER SEPARATION FROM OR COMPLETION OF THE PROGRAM (unless other date, event or condition upon which consent will expire is specified: _____).

I understand that, except in limited circumstances, the Residential Program may not condition my treatment on whether I sign a consent form.

Signature of Client Date Signature of Staff Witness Date

Signature of Parent / Guardian (if required) Date

Institute for Health and Recovery
349 Broadway, Cambridge, MA 02139
Phone (617) 661-3991 Fax (617) 661-7277
www.healthrecovery.org