Pre-Admission Packet – Action Recovery Brain Injury

Thank you for assisting in the referral process for an individual seeking services to our Action Recovery Program. To ensure a timely and efficient admissions process, please review and submit the required documents listed below. **Missing information may delay processing.**

If you need assistance gathering any required documents, our admissions team is available to support you.

Submission Instructions:

Scan or fax completed packets to **Bill Hoke and/or Crystal Yost** at:

📠 **Admissions Fax:** 610-928-0174

📧 **Email:** whoke@newvitaewellness.com | cyost@newvitaewellness.com

Required Documentation Prior to Admission:

- ☐ Completed Referral Form (Attached)
- ☐ Signed Release of Information Consent (Attached)
- ☐ Authorization and Understanding Statement/Consent for Criminal Background Check (Attached)
- ☐ Identifying Documents
  - Photo ID
  - Insurance Cards (Medicaid, Medicare, Private Insurance)
- ☐ Clinical Information (additional information may be requested)
  - ☐ Most Recent Psych Evaluation
  - ☐ Current Medication List
  - ☐ Current Progress/Treatment Notes
  - ☐ Biopsychosocial Evaluation (within 1 year)
  - ☐ Psychological/Neuropsych Eval/Assessment (within 1 year)
  - ☐ History and Physical
  - ☐ Substance Use Current and History
  - ☐ Current Treatment Plans/Summaries/Discharge Notes
- ☐ Psychiatric History and Placement Information *(if applicable)*
  - ☐ Previous Psychiatric Hospitalizations *(list dates and facilities)*
  - ☐ Previous Residential Treatment Placements *(list locations and dates)*
  - ☐ Elopement, Aggression, or Self-Harm Assessments/History *(if applicable, provide details)*
- ☐ TBI History *(timeline of treatment since inception)*
- ☐ Collateral Information: Family, Caregiver, Professional Stakeholder Information
- ☐ Legal Court Documents: Probation, Parole, Court Orders *(if applicable)*
- ☐ POA/Guardianship Paperwork (*if applicable)*

If you have any questions or require assistance gathering documents, please contact our **New Vitae Admissions Team.**

Thank You,

Bill Hoke, VP of Development
Crystal Yost, Marketing and Development
New Vitae Wellness and Recovery Admissions Team

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Consent for Release of Information

(One for each organization/facility and/or person)

I,_____, authorize the staff of ***New Vitae Wellness and Recovery*** to obtain from and/or release information to:

Organization, Name: **Phone:**

Address: **City:** **State:** **Zip:**

The following specific information (please check all that apply):

- ☐ Psychiatric Evaluation
- ☐ History and Physical
- ☐ Case Management Notes
- ☐ Psychosocial Evaluation
- ☐ Discharge Summary
- ☐ Other: _____
- ☐ Progress Notes
- ☐ Clinical Reviews

For the purpose(s) of (please check next to the items purpose):

- ☐ Admission Planning
- ☐ Emergency Contact
- ☐ Legal Background Check
- ☐ Other: _____
- ☐ Benefits Information

Information to be released covers the period from: ____/_____/_____ to ____/_____/_____

Acknowledgment and Consent

I understand that this authorization allows for the release or exchange of my confidential information as specified above. I have been informed that my written consent is required to obtain or disclose this information, except in cases permitted by law. This authorization is limited to the purpose(s) and person(s)/facility listed above and will remain in effect for the duration specified.

I further understand that:

- I have the right to revoke this consent at any time by providing written notice, except to the extent that action has already been taken in reliance on this authorization.
- Refusing to sign this form may impact my ability to receive certain services but will not affect my eligibility for treatment.
- Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal confidentiality laws.

Client Name:

Client Social Security #: Client Date of Birth:

Signature of Client/POA/Guardian: Date:

Witness Signature: Date:

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Authorization & Understanding Statement for Public Background Checks

I, _____ acknowledge that as part of the admission process at New Vitae Wellness and Recovery, the admissions team may conduct a public record background check using publicly available information.
I understand that:

- This search may include court records, Megan's Law registry, public legal databases, and other publicly accessible sources.
- No third-party screening agencies, private investigators, or credit history reports will be used.
- This check is for the purpose of assessing suitability for admission and ensuring the safety of all residents and staff.
- This process does not require the disclosure of my Social Security number.

I acknowledge that I have been informed of this process and understand its purpose.

Signature of Client/POA/Guardian: _____

Alias(es) / Other Names Used: _____

Date: ___ /___ /____

Printed Name: _____

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Admission Referral Form (Action Recovery/Brain Injury)

Section 1: Client Information

Last Name:	First Name:	M.I.:
DOB:	Age:	Social Security #:
Person identifies as: ☐ Male ☐ Female ☐ Non-Binary ☐ Other:		
Gender at birth: ☐ Male ☐ Female		
Race:	Identifying Marks:	
Primary Language:		
Address:		
Phone Number: (Cell)	(Home)	
Current Living Situation: ☐Independent ☐ With Family ☐ Another Placement (residential/group) ☐Hospital ☐ Homeless ☐ Other:		

Section 2: Referral Information

Referral Source (Agency/Person Referring):		
Address:		
Contact Person:	**Phone #:**	**Fax #:**
Email:		
Case Manager, if different from above:		**Phone #:**
Email:		
Current Placement:	**Date of Admit:**	
Voluntary:	**Disch. Plan:**	

Section 3: Contact Information and Legal Information:

*Provide all legal documents, if answered "Yes" to below questions

Emergency Contact:	**Relationship:**
Email:	
Address:	**Phone #:**
Is there a POA? ☐ Yes ☐ No	**POA Name:**
Address:	
Email:	**Phone #:**

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Is there a Legal Guardian? ☐ Yes ☐ No	**Guadian Name:**
Address:	
Email:	**Phone #:**
Is there a Rep Payee/Fiduciary? ☐ Yes ☐ No	**Rep Payee/Fiduciary Name:**
Address:	
Email:	**Phone #:**
Who is financially responsible (if self, write self)	**Name:**
Address:	
Email:	**Phone #:**
Service Coordinator:	**Phone #:**
Email:	

Finance/Insurance Information – Provide Copies of Insurance Cards

Primary Insurance:
Secondary Insurance:
Medicare #:

Section 4: Brain Injury Information

Date of Brain Injury:
Cause of Brain Injury:
Medical Complications due to TBI:
Current Level of Independence: ☐ Independent ☐ Requires Assistance with ADLs ☐ Full-Time Care Needed
Timeline of Events and Placements:

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History of Past TBI Residential Programs: *(Below provide name of programs and dates of residence. If none, write None.)*
Cognitive Challenges: *(Check all that apply)* ☐ Memory Loss ☐ Impulse Control Issues ☐ Difficulty with Problem Solving ☐ Difficulty with Attention/Focus ☐ Difficulty with Communication ☐ Other:
Behavioral Concerns: *(Check all that apply)* ☐ Verbal Aggression ☐ Physical Aggression ☐ Wandering/Elopement Risk ☐ Difficulty Following Directions ☐ Difficulty with Emotional Regulation
Current Treatment Team Contacts: • *Primary Physician:* _____ • *Neurologist (if applicable):* _____ • *Psychiatrist (if applicable):* _____

Section 5: Clinical and Medical (current and history)

Chief Complaint/Presenting Problem:	
Primary Diagnosis:	
Secondary Diagnosis(es):	
Addiction/SUD Diagnosis(es):	
Medical Diagnoses:	
Developmental Disorders:	
Cognitive Functioning:	
Current Symptoms: ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Fire Setting ☐ Self-Injurious Behavior ☐ Elopement Risk ☐ Aggression ☐ Violence ☐ Other(s):	
Seizures: ☐ Yes ☐No	**Dietary Needs:**
Allergies:	
Mobility Needs: ☐ Independent ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other:	
Vision or Hearing Challenges: ☐ Yes ☐ No **Assistive Devices:**	

Psychiatrist (if applicable)	**Name:**
Phone:	**Fax:**

Section 6: Mental Health History

History of Trauma: ☐ Yes ☐No Explain, if yes:
History of Psychiatric Hospitalizations or Treatment (List Dates & Facilities):
Previous Suicide Attempts (frequency) or Self-Harm ☐ Yes ☐No (If Applicable, List Dates):
History of Aggression, Elopement, or Fire-Setting: ☐ Yes ☐ No (If Yes, provide details):

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Section 7: Substance Use and History (If applicable)

Drug(s) of Choice:
Last Use (List All Substances & Dates):
Currently on MAT (Medication-Assisted Treatment)? ☐ Yes ☐ No
Type & Dosage:
History of Overdoses (Number & Last Date):
Previous Treatment: ☐ **Inpatient** ☐ **Outpatient** ☐ **None**
Longest Period of Sobriety:

Section 8: Legal Issues (if applicable)

Current or Past Legal Issues: ☐ **Yes** ☐ **No** (If Yes, provide details below):	
Probation or Parole Status: ☐ **Yes** ☐ **No** **(If Yes, provide details below):**	
Probation/Parole Officer Name:	**Phone:**
Pending Charges or Court Cases: ☐ **Yes** ☐ **No** (If Yes, provide details):	
Legal Issues Related to Sexual Assault or Abuse: ☐ **Yes** ☐ **No** If Yes, provide details: (Including Megan's Law, Sex Offender Status):	