Osage Nation Primary Residential Treatment Center

Phone: 918-287-5413 FAX: 918-287-5234
606 Kihekah
Pawhuska, OK 74056

Pre - Admission Packet

Name: _____ DOB: _____
(Last, First, MI)
Address: _____

City: _____ State: _____ ZIP: _____

Phone #:_____ Cell: _____

For Staff Use Only

Item	Date Rec'd/Completed	Comments
CDIB		
TB Result		
Hep Result		
ASI		
ASAM		
MH Eval		
Physical		
Detox Clearance		
Court Dates		
OSW		
Probation/Parole		
Felony Check		
Sex Offender Check		
DOC check		
Team Approval		
Client Notified		

Helping Those on the Way to Recovery

Dear Friend,

Ha. We. Thank you for inquiring about being admitted into our 60 day residential program. The following forms must be completed in full and returned as soon as possible so our treatment team can evaluate your needs. Once the treatment team has met, you will be notified of their decision. At that time, you may be admitted, be placed on the waiting list (subject to treatment availability) or referred to another treatment facility more appropriate for your needs.

1. **Medical Form (completed by physician)**
2. **Must have the results of TB and Hepatitis testing.**
3. **Copy of CDIB**
4. **Completed Addiction Severity Index (ASI) from referring agency or other resource such as outpatient clinic, Indian Health Services, DUI schools, or tribal health clinic.**
5. **An ASAM showing the need for residential treatment. This can be done by the same person that completes your ASI.**
6. **Completed Mental Health Evaluation from a licensed provider such as an LPC. This can be completed privately, or at a Community Mental Health Center, Indian Health Services, or Tribal Health Clinic.**
7. After we have received items 1 through 6 listed above we will arrange a phone interview with our intake coordinator.
8. Please inform the intake coordinator of any special needs such as dietary restrictions.

******Please be aware that if you are seeking admission for alcohol abuse, opiate abuse, or benzodiazepine abuse, you may be required to provide the facility with a letter from a doctor that either you require detox or are medically clear to enter the facility. This is different than the medical statement at the end of your physical. This letter from your doctor MUST be obtained within 24 hours of your admission to PRT.***

******Please be aware that you will have approximately 30 days to complete the application process. If you have not finished your application within 30 days, you will need to communicate with the intake coordinator as to why. If you do not, your application will be closed and you will need to restart the process.***

Once you have been accepted into treatment, please note the following:

- All medications should be filled for 60 days before admittance.
- All dental problems need to be taken care of before entering treatment.
- Bring Court Papers or DHS paperwork (If applicable).
- If you have any court dates, they will need to be deferred while you are in treatment.
- You will need to pass a UA (urine analysis) upon arrival in order to be admitted into the program.
- **You must be stabilized on any Prescription Behavioral Health/Anti-depressant medication for at least 2 weeks prior to being admitted into our program.**
- **All medication must be prescribed to you by a physician and must be non-narcotic.**
- If you did not bring the needed medication or if you bring medication that has not been approved during the pre-admission process, you cannot be admitted in the treatment program.
- **All Clients are financially responsible for any medication needs.**
- **If numerous visits to the clinic are necessary while you are in treatment you may be discharged until the health issue is resolved. You will then need a statement from your doctor giving you medical clearance to return to treatment (within 30 days)**

If you have questions please feel free to contact our Intake Coordinator at (918) 287-5413.

The Primary Residential Treatment Team

PRT MEDICAL FORM

I. Patient Information:

DATE: _____

NAME: _____

(Last, First, MI)

Address: _____

City: _____ State: _____ZIP: _____

DOB: _____ Age: _____ Sex: _____

Tribe: _____

II. Medical History (Relevant History) _____

_____

_____

_____

_____

_____

_____

Allergies: _____

_____

III. Other Physical Findings:

Height: _____ Weight: _____ BP: _____

HEENT: _____

Heart: _____

Lungs: _____

Abdomen: _____

Extremities: _____

Vital Signs: _____

PPD Results (Need copy): _____

Date and Time read: _____

Hepatitis Panel Lab Findings: _____

Visual Acuity R/L: _____

Other Significant Findings: _____

_____

IV. Physical Limitations/Safe for Work Assignments: (i.e. kitchen duty) _____

_____

_____

_____

Is this client able to participate in a fitness program under the supervision of a trainer? ☐ YES ☐ NO

Are there any recommended precautions/restrictions for this fitness program? _____

_____

_____

_____

V. Smoking Cessation: Does this person smoke? ☐YES ☐NO

Have you counseled the patient on smoking cessation? ☐YES ☐NO

What are your recommendations for smoking cessation? _____

_____

VI. Prescribed Medications: (Prescription medications-including dosage- and any past use of medications which may have helped or caused more distress.)

_____

_____

_____

_____

*** Please ensure that prescriptions which are needed by the pt are filled for a minimum of 45 days.**

*** Please note any use of inhaler and if client needs to keep inhaler with them.**

Please indicate which over the counter medications that the patient may also be given as needed.

Tylenol_____ Aspirin_____ Other_____

Physician Statement: _____

_____

_____

_____

On _____, I examined _____and found this patient to be considered medically stable to participate in residential treatment for alcohol and/or substance abuse.

_____ _____

Physician Name Printed **Date** **Signature of M.D., D.O., F.N.P., or P.A.**

Name of Medical Facility: _____
Address: _____
Phone: _____ Fax_____

Mail, Phone, and Smoking Protocol

Mail

- Can be sent out daily
- Clients must have their own postage
- PRT will provide paper and envelopes for mailing
- No mail can be received from any jail or Department of Corrections Institution such as a prison
- All mail incoming and outgoing must be appropriate and not have explicit content
- Incoming mail is picked up at the ONCC building by staff and will be given to the clients
- If it is determined that incoming mail contains something hazardous or has inappropriate content the mail will be confiscated
- All mail is subject to inspection

Electronic Mail

- Computers are not to be used in the PRT facility due to confidentiality of materials which may be located on the computer.
- No electronic devices are permitted in PRT program at any time; this includes cell phones, radios, tablets, laptops or anything which is considered an electronic

Phone Calls

- Phone calls can be made at the PRT facility between 2:00 – 4:30 on Tuesdays or Fridays.
- Clients must have a calling card to pay for long distance calling.
- All calls will be approved and monitored by the Program Coordinator or Counselor.

Smoking

- Smoking is allowed on a scheduled basis only.
- Clients are responsible for having their own cigarettes.
- Staff are unable to provide clients with cigarettes during their stay.

_____

Client Signature Date

Osage Nation Primary Residential Treatment

ITEMS NEEDED:

- 7-10 days of clothing, including a seasonally appropriate jacket/coat
- Tooth Paste & Tooth brush
- Shampoo, body wash, deodorant, razors, etc.
- Court Papers
- Brush/comb
- Cigarettes, Nicotine patches, gum, or lozenges
- Calling Cards—(You must bring if you want to make your weekly call.)
- Stamps & Envelopes
- Medication for 60 days—if applicable
- Towels & Washcloths
- Blankets, Sheets, Comforters, and Pillows for a twin size bed
- Appropriate gym clothes such as t-shirts, sweat pants, shorts, and tennis shoes

**** You must bring enough toiletries to last the duration of your stay. If necessary, family may bring you more during visitation times on Sundays.**

DO NOT BRING:

- Cell Phone
- Radios or other electronics
- Knives
- Fingernail Polish Remover
- Food/Snacks and/or Pop
- Mouthwash containing Alcohol
- Clocks
- Clothing Advertising Alcohol and/or drugs
- No more than $20.00

Please note the following dress code:

Women: The following items are NOT allowed - Spaghetti strap tops, tank tops, strapless tops, halter tops, bikini tops/bottoms, low cut shirts/blouses, short or micro skirts, short or micro shorts, and jeans/shorts with rips and/or tears in inappropriate places. Appropriate undergarments are expected to be worn with clothing. Appropriate clothing MUST be worn at the gym, including tennis shoes.

Men: Tank tops, "wife-beater" shirts, short shorts, and jeans/shorts with rips and/or tears in inappropriate places. Appropriate clothing MUST be worn at the gym, including tennis shoes.

***Any item brought that is not allowed will be taken away until after you leave treatment.**
***Anything left at the treatment center when you leave will be held for two weeks then disposed of.**

OSAGE NATION COUNSELING CENTER
606 Kihekah Pawhuska, OK 74056 Phone: 918-287-5413 Fax: 918-287-5234

CONSENT FORM FOR RELEASE OF CONFIDENTIAL INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my health record.

Date of Birth: _____

The information is to be released by: And is to:

NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
Osage Nation Counseling Center	
ADDRESS	ADDRESS
606 Kihekah	
CITY/STATE/ZIP	CITY/STATE/ZIP
Pawhuska, OK 74056	

The purpose or need for the disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐Personal Use ☐ Insurance ☐ Disability

☐ Other (Specify)_____

The information to be disclosed from my consumer file: (check appropriate box (es) :

☐ Entire Record

☐ Only information related to (specify) _____

☐ Only the period of events from _____ to _____

☐ Other (specify_ _____

☐ Alcohol/Drug Abuse Treatment /Referral

☐ Mental Health (Other than Psychotherapy Notes)

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO: DISEASES, SUCH AS HEPATITIS, SYPHILLIS, GONORRHEA AND INFECTION WITH THE IMMUNE DIFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFIENCY SYNDROME (AIDS). [63 O.S. § 1-1502 (b)]

This client's written consent for the release of information shall be considered valid due to the following conditions having been met:

1. The client is informed, in a manner that assures his or her understanding of the specific type of information that has been requested, and the period of time for which the information has been requested.
2. The client is informed of the purpose or need for this information.
3. Treatment services are not contingent upon or influenced by the client's decision concerning authorization of the release of information.
4. The client gives his/her consent freely and voluntarily: and
5. If the client is part of the criminal justice system, the client understands that the person receiving this information may disclose and use it only to carry out that person's official duties with regard to the client's original proceedings with which this consent is given.

I understand that the records requested may be protected under C.F.R.42 Part2. Governing Alcohol and Drug Abuse Patient Records and State Confidentially laws and regulations and cannot be released without my consent unless otherwise provided for by the regulation. State and Federal Law regulations prohibit further disclosure of such records with my specific written consent or except when otherwise permitted by such regulations.

I also understand that I may revoke this consent (in writing) at any time unless action has already been taken based upon it, and that in any event this consent expires (90) days form the date of signing or upon conditions described above, unless a longer period is specified.

_____ _____

Signature of Consumer, Parent, Guardian or Authorized Representative when Required Date

_____ _____

Signature of Counselor or Collector Date

NOTICE OF RECIPIENTS OF ALCOHOL AND DRUG ABUSE RECORDS

Each disclosed sheet of information shall contain the following statement stamped in RED: "This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2) The federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient"