Project Turnabout Detox Referral Form

Fax to: 320-564-3122 | Online:projectturnabout.org/admissions

PATIENT INFORMATION

Referring Facility Information: _____

Referring Provider Name: _____
Name & Title

Phone Number for Callback: _____

Fax Number: _____

Date/Time of Referral: _____

Patient Name: _____
First / Last

Address: _____

Phone: _____

DOB: _____

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone: _____

Insurance Provider: _____

Policy # _____

Authorization # _____

PROJECT Turnabout CENTERS FOR ADDICTION RECOVERY

CALL 800.862.1453

Granite Falls, MN
projectturnabout.org
FAX: 320-564-3122

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CLINICAL INFORMATION

Presenting Concern: _____

Last use (what/when) _____

Observed withdrawal symptoms: _____

_____

Allergies _____

Temperature: _____ BP: _____ / _____ HR _____ BPM

RR _____ /min O_2 sat _____

Current Suicidal Ideation: ☐ YES ☐ NO ☐ UNKNOWN ☐ N/A

Homicidal Ideation: ☐ YES ☐ NO

Active Psychosis/Severe Agitation: ☐ YES ☐ NO

Explain if yes to any of the above: _____

_____

Pregnancy: ☐ YES ☐ NO ☐ UNKNOWN ☐ N/A

If pregnant, gestational age: _____

OB Clearance Attached: ☐ YES ☐ NO

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LEGAL / REFERRAL STATUS

☐ Voluntary ☐ Court-Ordered ☐ Probation/Parole ☐ Law Enforcement Hold

☐ 72-Hour Hold ☐ Other _____

REQUIRED DOCUMENTATION

☐ Recent Labs (BAL, UDS, pregnancy if applicable)

☐ Medication List / Current Concerns

☐ Mental Health Clearance (if indicated)

☐ Discharge Summary / Transfer Orders

☐ ROI / 42 CFR Part 2 Consent (if available)

Transportation

☐ Hospital ☐ Family/Friend ☐ Law Enforcement ☐ Project Turnabout

☐ Other _____

Consents & Attestations

☐ I attest the patient meets admission eligibility (no IV meds/continuous monitoring; able to complete ADLs; medically stable; not actively psychotic/violent/heavily sedated; if pregnant, OB documentation attached).

Provider Signature _____ Date _____

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Complete Online