Intitial Referral Form

Youth Recovery Center
VALLEY VIEW

Please fill out the following form in its entirety. Please note we only accept adolescents ages 15-18 with dual diagnoses of moderate to severe substance use disorder and a mental health diagnosis. If your referral meets the admission criteria for **American Society of Addiction Medicine (ASAM) 4th Edition Level 3.5 Residential Treatment program**, we require additional documentation prior to acceptance into our program. A recommendation for ASAM Level 3.5 care does not automatically result in admission to YRC. YRC uses a trauma-informed, person-centered approach to referral and admission. Our goal is to understand each young person's strengths, needs, preferences, safety considerations, family and recovery environment, and treatment history so we can determine whether YRC can safely and effectively meet their needs. When we receive admission paperwork and clinical documentation, the multi-disciplinary treatment team reviews the referral. The referring party will then be notified whether YRC is an appropriate clinical match for the youth's current treatment needs. When YRC is not able to meet the youth's needs, we will communicate the clinical reason for that determination to the referring party, as permitted by applicable privacy requirements. A bed date (admission date) is determined AFTER acceptance and after all intake paperwork is received. If youth is considered to be an appropriate fit for our residential program, the following formal paperwork and clinical documentation will be required following this referral form.

If youth is considered to be an appropriate fit for our residential program, the following formal paperwork and clinical documentation will be required following this referral form:

1. A recent (within 6 months) ASAM assessment or a general mental health and substance use assessment. This assessment must recommend residential inpatient level of care to be considered for admittance to YRC. Dual diagnoses must be listed on this document. **Substance use disorders must be moderate or severe to be considered for YRC admission**.
2. A residential treatment recommendation/treatment referral from a current mental health professional. Please include the length and nature of the provider's involvement with the youth, the clinical rationale for recommending residential treatment, the youth's response to previous or current services, and the specific needs that may be better addressed in a residential setting. This referral must document dual diagnoses (substance use/mental health) an include documentation of ASAM Dimension Requirements (below):

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

- Intoxication and Associated Risks
- Withdrawal and Associated Risks
- Addiction Medication Needs

Dimension 2: Biomedical Conditions

- Physical Health Concerns
- Pregnancy-Related Concerns
- *Sleep Concerns**

Dimension 3: Psychiatric and Cognitive Conditions

- Active Psychiatric Symptoms
- Intellectual and Developmental Concerns
- *Trauma Exposure and Related Needs**
- *Psychiatric and Cognitive History**

Dimension 4: Substance Use-Related Risks

- Likelihood of Engaging in Risky Substance Use
- Likelihood of Engaging in Risky SUD-Related Behaviors

Dimension 5: Recovery Environment Interactions

- Ability to Function Effectively in Current Environment
- Safety in Current Environment
- Support Current Environment
- *Educational Needs**
- *Cultural Perceptions of Substance Use**

Dimension 6: Person-Centered Considerations

- *Patient Preferences**
- *Family Preferences**
- *Barriers to Care**
- *Need for Motivational Enhancement**

**Italicized items do not impact level of care recommendations, but are considered in treatment planning*

Please email your **completed referral forms A and B**
directly to our Admissions Team at:

YRCadmissions@vvh.org

You may also fax it to: 970.384.8470

To check on the status of your referral please call us at 970.384.8460.

FORM A

Referring Party/Main Point of Contact for Referral:

Email and Phone Number:

Name of Youth Being Referred:

Parent/Guardian Name:

Parent/Guardian Contact Info:

FORM B

Check the following that apply to the youth being referred:

- ☐ Has dual diagnosis
- ☐ Age 15-18
- ☐ Motivated for treatment
- ☐ Prior treatment attempts (outpatient, IOP, residential)
- ☐ Currently on probation
- ☐ Court ordered treatment
- ☐ GAL (GAL Name: _____)
- ☐ DHS Involvement (Caseworker name: _____)
- ☐ Legal Charges (Please list: _____)

Please include the length and nature of the provider's involvement with the youth, the clinical rationale for recommending residential treatment, the youth's response to previous or current services, and the specific needs that may be better addressed in a residential setting.

Any other comments: