CORSICA RIVER
Mental Health Services
Subsidiary of Crossroads Community, Inc.

Mental Health & SUD Services

Centreville
120 Banjo Lane
Centreville, MD
21617
Phone: 410-758-2211
Fax: 410-758-0698

Cambridge
502 Poplar Street
Cambridge, MD
21613
Phone: 443-225-5780
Fax: 443-225-5783

St. Michaels
933 S. Talbot Street
St. Michaels, MD
21663
Phone: 410-745-8028
Fax: 410-758-0698

SUD Services Only

Easton
300 Talbot Street
Easton, MD 21601

Denton
114 Market Street
Suites 205 & 207
Denton, MD 21629

Chestertown
516 Washington Street
Suite 4
Chestertown, MD
21620

Substance Use Disorder Treatment

Thank you for your interest in Corsica River Mental Health Services, Inc. The enclosed packet contains the items you will need to complete prior to coming into the clinic for open enrollment for services. Along with the enclosed packet of information, we also need you to bring the following documentation:

All current Insurance Cards – primary & secondary*
Photo ID
Patient Social Security Card
Primary Medical Doctor's name, address, and phone number

It is requested you bring the following, if applicable:
Discharge Summaries from Inpatient Treatment Facility
Documentation from Judicial Cour Systems

*If you/your child currently has no insurance, please bring in the following for income verification:
3 most current pay stubs
OR
Prior Year Tax Return

REGISTRATION FOR SERVICES CALL 410-758-2211 and ask to be registered for services at the location appropriate for your needs.

Acceptance and schedule for Assessments/Treatments is dependent on qualifying for services and, if required obtaining authorizations for services.

Failure to provide all necessary documents can result in no scheduled clinical visits.

*** Please be advised: There is a Wait List for ALL Private Insurance. In order to be added to the list, Registration process must be completed. ****

Corisca River Mental Health Services, Inc. is a non-profit mental health and Substance Use Disorder (SUD) clinic. Our mission is to provide caring, effective, and highly accessible assessment and treatment to all mid-shore residents through our clinics in Centreville, St. Michaels, and Cambridge.

Corsica River Mental Health Services, Inc. Date: _____
SUD--Client Information / Referral Form

PLEASE PRINT CLEARLY

Client's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone#: (home) _____ (work) _____ (cell) _____

Social Security #: _____ Date of Birth: _____

Age: _____ Race: _____ Marital Status: _____ Gender: Male Female

Primary Care Physician: _____ Phone#: _____

Address: _____

Date last seen: _____

Allergies: _____ E-Mail Address _____

Employed: Full Time Part Time Not Employed

Employer: _____

Address: _____ Phone: _____

Spouses Employer (if applicable): _____

Address: _____ Phone: _____

Insurance Provider: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ County: _____

Phone#: (home): _____ (work) _____ (cell) _____

Social Security # _____ Date of Birth: _____

Secondary Insurance Provider: _____ Policy # _____ Group #: _____

Policy Holder's Name: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ County: _____

Phone#: (home): _____ (work) _____ (cell) _____

Social Security # _____ Date of Birth: _____

Primary Emergency Contact

Name: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

See Reverse Side

Client Name _____

Additional Emergency Contacts

Name: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

Name: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

Referral Information (please use additional sheet of paper if necessary)

Person/Agency Referring: _____ Relationship: _____

Contact Info: Phone #: _____ Fax: _____ Email: _____

Reason for Referral: _____

_____

_____

_____

Prior mental health treatment (include names, dates of psychiatric hospitalizations and please specify if you are a current client with other providers): _____

_____

_____

_____

Previous Psychological Testing (please attach copies of reports): _____

_____

Current Medications: _____

_____

Substance Abuse History: _____

_____

Legal Issues / Guardianship/ Court Orders / Probation: _____

_____

Suicidal / Homicidal / Paranoid Ideations / Hallucinations: _____

_____

Significant Medical History (include developmental difficulties, allergies, toxicity, surgeries, illnesses, etc. with approximate dates): _____

_____

Are you a Veteran? ____ Yes ____ No Did you serve in Iraq and/or Afghanistan conflicts? ___ Yes ___ No

Client Name:_____

CORSICA RIVER

SUBSTANCE USE DISORDER QUESTIONAIRE

1. MARITAL STATUS_____
2. NUMBER OF DEPENDENT CHILDREN_____
3. LIVING SITUATION... Private Residence
   Foster Home
   Residential Care
   Jail
   Homeless
   Other
4. Employment Status _____
5. Source of Referral .....
   Juvenile Justice Agency _____
   DWI/DUI Referral _____
   Pre-Trial Services Agency _____
   Probation/Parole _____
   State Prison _____
   Local Detention Center _____
   Drug Court _____
   Self Referral _____
   DSS Assessment Unit _____
6. Number of Lifetime Admissions to SRD Treatment _____
7. Primary source of income _____
8. Type of Insurance _____
9. Mental Health Problems ... YES or NO
10. Do you have a diagnosis of Tuberculosis? _____
11. Tobacco use 30 days prior to Admission? _____
12. Treatment Setting?.....
    Community_____
    Local Detention Center _____
    State Dept. of Corrections _____
13. Highest level of school completed? _____

Client Name:_____

14. Are you a veteran? _____
15. Number of arrests in the last 30 days _____
16. Number of arrests in the last 12 months _____
17. Number of times in Self-Help Group in last 30 days _____
18. Primary method of payment for treatment.....

DHMH Grant _____
Medicaid _____
Medicare _____
Drug Court _____
Other public funds _____
Out of pocket _____
Other _____

19: Primary substance.....(Drug of Choice, please number as appropriate ex: #1 most commonly used, 2-3, etc.)

	Age of First Used
Alcohol _____	_____
Amphetamines _____	_____
Barbituates _____	_____
Cocaine/Crack _____	_____
Hallucinogens/ LSD _____	_____
Inhalants – Aerosols _____	_____
Marijuana/Hashish _____	_____
Opiates – Heroin _____	_____
Opiates – Vicodin _____	_____
Opiates – Demerol _____	_____
Opiates – Oxycodone _____	_____
OTC – Benadryl _____	_____
Sedatives/Quaaludes _____	_____
Stimulants / Ritalin _____	_____
Tranquilizers _____	_____
Other Substances _____	_____

Client Name:_____

Total years of use.....

- **Less than one month _____**
- **1 – 6 months _____**
- **6 months – 1 year _____**
- **1 year of longer _____**
- **Unknown _____**

Usual route of Administration.....

- **Oral _____**
- **Smoking _____**
- **Inhalation _____**
- **Injection _____**
- **Other _____**

Date of Last Use of any substance:_____