

## MINNESOTA INDIAN PRIMARY RESIDENTIAL



### TREATMENT CENTER

Thunderbird & Wren House  
220 N. 4<sup>th</sup> Avenue West  
Duluth, MN 55806  
(218) 727-7699 \* (218) 722-2703  
Fax: (218) 727-1476



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In order to confirm an admission for an individual at our Thunderbird/Wren House, we need the following information:

- A copy of the CD Assessment/Rule 25 including the Summary/Recommendations page
- A copy of a physical completed for the client within 30 days of admission to Thunderbird/Wren.
- Verification of funding: A copy of the completed and signed CPA from the client's county or reservation for CCDTF funding, must be on file prior to the client's admission to the halfway house. Insurance clients must have preauthorization from their insurance company prior to admission
- A Release of Information signed by the client for MIPRTC to communicate with the referent and funding agent regarding information required for admission. Copy this form as needed.

To reserve a bed for our halfway house facility, please complete the attached Pre-Admission Information Sheet and fax it to the attention of Admissions at fax # 218-727-1476. **Please note that an admission day/date cannot be confirmed until all forms are on file with our facility.**

Thanks in advance for your time - Admissions

The document (s) accompanying this telecopy transmission contains information from the sender which is confidential and/or privileged. This information is intended to be for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure, copying, or use of the contents of this information is prohibited, and may constitute invasion of the privacy of the intended recipient. If you have received this telecopy in error, please notify us by telephone (collect) immediately so that we can arrange for the retrieval of the original document at no cost to you.

AN AMERICAN INDIAN RESIDENTIAL TREATMENT CENTER FOR CHEMICAL DEPENDENCY

# Thunderbird/Wren Pre-admission Information Sheet

**Admit Date** (requested): \_\_\_\_\_ **NOTE:** That does not mean a bed will be available on that date!

**Date of Assessment:** \_\_\_\_\_ **Dimensions:** 1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_ 4: \_\_\_\_\_ 5: \_\_\_\_\_ 6: \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City & State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_ **Soc Sec #:** \_\_\_\_\_

**Reservation:** \_\_\_\_\_ **Enrollment #:** \_\_\_\_\_

**Emergency Contact (Name & relationship):** \_\_\_\_\_ **ph#:** \_\_\_\_\_

**Referent:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**Referring Agency:** \_\_\_\_\_ **Address:** \_\_\_\_\_

Did this person do the original assessment?: Yes/No If no, who did? Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Ph#: \_\_\_\_\_

**Funding** (# of days in treatment): \_\_\_\_\_ Check one: \_\_\_\_\_ Consolidated Funds through: \_\_\_\_\_

Insurance: Company: \_\_\_\_\_

PMI #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Deductible: \_\_\_\_\_ CoPay: \_\_\_\_\_

**Medical Condition (s):** \_\_\_\_\_

**If client is female, is she pregnant?** Circle Yes or No If Yes, additional information may be requested.

**Prescription Medications:** \_\_\_\_\_

**Has the client ever been diagnosed with a Mental Health Disorder?** Circle Yes or No **If Yes, please**

**specify Mental Health Issues/Diagnosis/Meds:** \_\_\_\_\_

**Has the client ever been charged with a sexual assault?:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Court ordered:** Yes or No (circle one) **If yes, through Soc. Serv. or Criminal Court?** (circle one)

**Legal Issues:** \_\_\_\_\_

**Probation Officer's Name:** \_\_\_\_\_ **ph#:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City & State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

\*\*\*Any information left blank could delay our ability to reserve a bed for your client\*\*\*

**MINNESOTA INDIAN PRIMARY RESIDENTIAL TREATMENT CENTER, INC.**  
**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I,  authorize   
 (name of client giving consent)

to disclose to   
 (person or

organization to which disclosure is to be made)

**NATURE OF INFORMATION**

	YES	NO		YES	NO
Physical Exam Appointment	<input type="checkbox"/>	<input type="checkbox"/>	Drug History	<input type="checkbox"/>	<input type="checkbox"/>
Physical Exam Report	<input type="checkbox"/>	<input type="checkbox"/>	Legal History	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Evaluations	<input type="checkbox"/>	<input type="checkbox"/>	Initial Treatment Plan	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Evaluations	<input type="checkbox"/>	<input type="checkbox"/>	Progress Report	<input type="checkbox"/>	<input type="checkbox"/>
Medical History	<input type="checkbox"/>	<input type="checkbox"/>	Referral Letter	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis Results	<input type="checkbox"/>	<input type="checkbox"/>	Aftercare Plan	<input type="checkbox"/>	<input type="checkbox"/>
Social History	<input type="checkbox"/>	<input type="checkbox"/>	Funding	<input type="checkbox"/>	<input type="checkbox"/>
Billing	<input type="checkbox"/>	<input type="checkbox"/>			

Other (specify)

Purpose of Disclosure:

I understand the my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Executed this  day of     
 Month Year

Signature of Client \_\_\_\_\_ Signature of Witness \_\_\_\_\_

This record was digitally signed in compliance with the Minnesota Electronic Authentication Act. The Minnesota Indian Primary Residential Treatment Center creates, maintains and preserves electronic patient records on a system which ensures the records are authentic, reliable, complete and accessible in accordance with Minnesota and federal law.

MN Indian Primary Residential Treatment Center, Inc.  
 P. O. Box 66 - 1150 Mission Road  
 Sawyer, MN 55780

Phone # (218) 879-6731  
 Fax # (218) 879-6734 (Adult)  
 Fax # ~~(218) 878-2947 (Adolescent)~~

**FOR PHYSICIAN ONLY**

Patient Name
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Blood Pressure (Sitting)	Temperature
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Height	Weight	Pulse	Vision W/O Glasses	Distant (Standard) R. L.	Near (Linear values) R. L.
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CHECK (X) WHETHER Normal (N) or Abnormal (A)	N	A
1. Nutrition		
2. Development		
3. Scalp & Head		
4. Skin		
5. Eyes		
6. Ears		
7. Nose & Sinuses		
8. Throat		
9. Teeth & Gums		
10. Thyroid Gland & Neck		
11. Lymph Glands		
12. Chest		
13. Breasts		
14. Lungs		
15. Heart		
16. Abdomen		
17. Inguinal Rings		
18. Genitals		
19. Prostate		
20. Rectal		
21. Spine		
22. Extremities		
23. Neurological, General		
24. Personality, General		
25. Menstrual Disorders		

Vision With Glasses	R. L.	R. L.
Color Vision	ISHIHARA DVORINE	

HEARING	Right	Left
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TEST RESULTS Normal (N) Abnormal (A)	N	A
A. URINALYSIS		
B. MANTOUX (within last yr.)		
C. CHEST X-RAY (if positive)		
D. IMMUNIZATIONS(on record)		

Dx: 1. Alcoholism  
 stage: \_\_\_\_\_  
 2. Drug Dependency  
 stage: \_\_\_\_\_

Other Dx: \_\_\_\_\_

Client is apparently free of communicable diseases within the limitations of this examination. Yes \_\_\_\_\_ No \_\_\_\_\_

CLINIC/FACILITY:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone # \_\_\_\_\_  
 Fax # \_\_\_\_\_

Is this person free of any chronic or acute medical problems likely to become exacerbated? If not, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Acceptable for limited type of Placement - List restriction:

Date: \_\_\_\_\_

By: \_\_\_\_\_ M.D.

## THUNDERBIRD ~ WREN HALFWAY HOUSE PROGRAM

The halfway house is located at 229 North 4th Avenue West in Duluth, Minnesota and is a twenty-one bed facility for American Indians who are chemically dependent. The program accepts males and females sixteen years of age and above. The halfway house program provides problem assessment and treatment planning, life-skills assessment, independent living skills, individual and group counseling, and a cultural/traditional experience. Routine medical services are available through the Center for American Indian Resources in Duluth, Minnesota for enrolled members of federally recognized tribes. For clients in need of psychological services, a psychologist is available.

**M**innesota Indian Primary Residential Treatment Center, Inc. provides a continuum of care for American Indians who suffer from alcoholism and/or drug abuse. The agency provides numerous treatment programs and is located on the Fond du Lac Reservation in Sawyer, Minnesota and in Duluth, Minnesota. MIPRTC, Inc. is an American Indian owned and operated agency.

The treatment approach in our programs is holistic as it blends Native American culture and traditions with the principles of recovery and Alcoholics Anonymous. Clients receive information concerning addiction and recovery. They are taught basic strategies in maintaining sobriety. They also have the opportunity to engage in traditional Native American practices and traditions.

## Referrals Inquiries & Admissions

### Mash-ka-wisen Numbers:

Phone: 1-218-879-6731

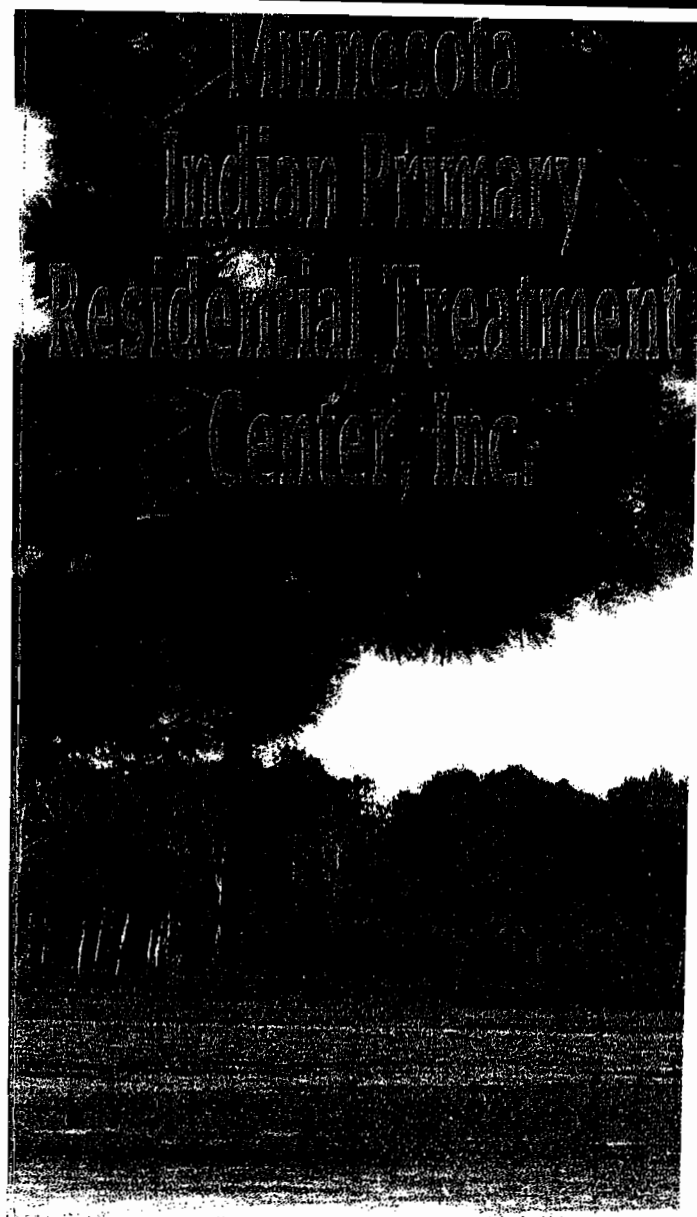
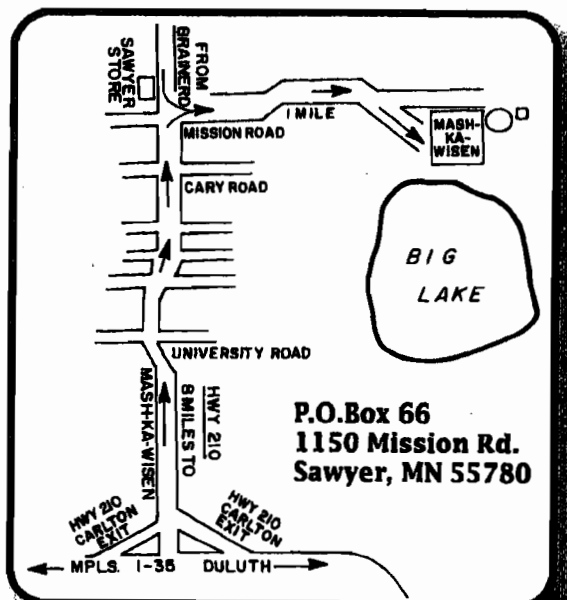
Adolescent Fax: 1-218-878-2947

Adult Fax: 1-218-879-6734

Thunderbird-Wren Halfway House

Phone: 1-218-727-7699

Fax: 1-218-727-1476



For referrals, contact admissions at

**1-218-879-6731**

(Mash-ka-wisen) or

**1-218-727-7699**

(Thunderbird-Wren)

**CARF Accredited  
Treatment Programs**