# MINNESOTA INDIAN PRIMARY RESIDENTIAL TREATMENT CENTER

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

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

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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***