RETORNO
PREVENTION & TREATMENT OF ADDICTION

Application for Referral and Treatment

Date_____

Name_____ Passport#_____

Address_____

Home Phone_____

Cell Phone _____

I hereby affirm that I have approached RETORNO of my own free will. I would like to receive assessment, advice, and treatment. I am committed to complying with the rules of the institution.

I hereby affirm that all information provided is accurate and the most recent information available. I understand that the inclusion of incorrect or outdated information or omission of relevant information may disqualify me at any time during the application or treatment process.

Signature_____

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Background Profile
(to be filled out by patient or guardian)

Date_____ Social Security # _____
Patient Name_____ Date of Birth_____
Address_____ Country: _____
Home phone: _____ Cell phone: _____

Family Description_____
_____

Childhood_____
_____
_____

Adolescence_____
_____
_____

Description of present situation_____
_____
_____
_____

Is there a history of behavioral problems in school? Please describe._____
_____
_____

Educational Evaluation: Yes/No If yes, please enclose a copy of the full report.

Psychiatric/Psychological Evaluation: Please send full written report (depression, suicide attempts, violence, diagnoses).

List of medications (including dosage): _____
_____
_____
_____

Prior Therapy_____
_____
_____

Motivation for treatment_____
_____

Expectations_____
_____

Filled out by _____ Relationship to patient: _____
Signature_____

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Medical Statement
(to be filled out by Patient)

I, _____, Social Security #: _____, declare that I do not suffer any medical issues, other than what is listed below:

1.	Orthopedic:	yes/no	details:_____
2.	Psychiatric:	yes/no	details:_____
3.	Digestive:	yes/no	details:_____
4.	Respiratory:	yes/no	details:_____
5.	Cardiology:	yes/no	details:_____
6.	Vascular:	yes/no	details:_____
7.	Dermatology:	yes/no	details:_____
8.	Reproductive:	yes/no	details:_____
9.	Epilepsy:	yes/no	details:_____
10.	Other:	yes/no	details:_____

I affirm that I am/am not physically limited in any way. If yes then provide details:
_____

I affirm that I do/do not take any medications. If yes, list medications and dosage:
_____

I hereby state that all the above is true, and that if any of the above is not true or I have omitted any information, then Retorno has the right to refuse or terminate my treatment immediately and without prior notice, and that Retorno is not liable, legally, medically or otherwise, for any possible consequences due to omission or incorrect information.

Full name: _____
Signature: _____
Date: _____

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Medical Form
(to be filled out by physician)

Date_____

Name_____
Passport# _____
Date of birth _____

General Appearance_____
_____
_____

History of Medical Problems_____
_____
_____
_____

Hospitalizations_____
_____
_____
_____

Present Situation_____
_____
_____
_____
_____

Is this patient fit to withstand the stresses of treatment? _____

Name of Examining Physician_____

Signature and Stamp_____

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Lab Tests

1. EKG
2. Chest Xray, radiologist's report only
3. Blood count, Hematocrit, Thrombocytes
4. Biochemistry:
    - Glucose
    - Urea
    - Creatinine
    - Bilirubin:
    - total
    - direct
    - Total protein:
    - Globulin
    - Albumin
    - Cholesterol
    - Triglycerides
    - Uric Acid
    - Chlorid
    - Sodium
    - Potassium
    - Amylase
    - Alk.Phosphatase
    - SGOT,SGPT,GGT
    - VDRL
    - HBs HepC Ag
    - HIV
    - Urine HTT (for women)

Please note that missing tests will delay treatment!

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Confidentiality Release Form

Date_____

I_____, ID or Passport #_____, hereby release all medical and other personal information, and allow RETORNO to acquire any related information that may be required. This will be made available upon request and sent directly to RETORNO.

_____
Signature