DAYBREAK youth services
igniting hope • saving lives

Daybreak Youth Services Residential Inpatient Care Application

Please mail or fax the attached form after filling it out to the best of your ability. Daybreak's admissions team will contact you by phone or email within one working day of receiving your application.

Mailing address for Brush Prairie clients:

Daybreak Youth Services ATTN: Admissions
Department11910 NE 154th St.
Brush Prairie, WA 98606

Mailing address for Spokane clients:

Daybreak Youth Services ATTN: Admissions
Department628 S. Cowley St.
Spokane, WA 99202

Daybreak admissions contacts:

Amanda Kerr, Spokane Inpatient Admission Manager
Phone: (509) 624-3227 x1003
Fax: (509) 835-4272
Email: akerr@daybreakyouthservices.org

Katie Conner, Brush Prairie Director of Admissions/Operations
Phone: (360) 750-9588 x3003
Fax: (360) 750-9718
Email: kconner@daybreakyouthservices.org

If you have any questions about the admissions process, please give us a call at **(888) 454-5506**. Thank you!

Section 1: Patient Information

Please provide as much information as possible. Incomplete applications cause delays in processing.

Patient's name: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Nonconforming

Date of birth:_____ **Social Security Number:** _____

Street address: _____

City: _____ **State/Province/Region:** _____ **ZIP:** _____

Section 2: Form Submitter Information

Form submitter's name: _____

Phone:_____ **Email:** _____

Relationship to the patient: _____

Are you the patient's legal guardian? (If "yes," skip Section 3) ☐ Yes ☐ No

What is your preferred contact method? ☐ Phone ☐ Email

How did you hear about Daybreak? _____

Section 3: Legal Guardian Information

Legal Guardian's name: _____

Phone:_____ **Email:** _____

Section 4: Patient History

Has the patient had an outpatient drug and alcohol assessment? ☐ Yes ☐ No

Why does the patient need residential treatment?

_____

_____

_____

Statement from the patient about why they want to come to treatment

_____

_____

_____

_____

Name of licensed drug and alcohol counselor: _____

Agency Name: _____

Agency Phone: _____

Is the patient pregnant? ☐ Yes ☐ No

What are the most recent substances used? Please add the frequency, date and amount used.

_____

_____

_____

Is the patient an IV drug user? ☐ Yes ☐ No

Does the patient use nicotine? ☐ Yes ☐ No

If "yes", please describe type and daily usage_____

Is the patient on probation? ☐ Yes ☐ No

If "yes," please provide:

Probation officer's name: _____

Probation officer's phone: _____

Section 5: Patient Medical History

Please list any medical issues the patient has been diagnosed with as well as any treatments being used to help control symptoms (Examples: asthma, diabetes, seizures, thyroid, constipation, etc.)

Medical issue **Treatment**

_____

_____

_____

_____

_____

Note: If the patient has Type 1 Diabetes and uses insulin, or has had a seizure within the past year, we must have a recent note from the prescribing provider with details of care plan prior to coming to Daybreak.

Does the patient currently have any of the following symptoms? (check all that apply)

☐ A cough lasting for 3 weeks or longer ☐ Coughing up blood

☐ Fever or night sweats ☐ Unexplained weight loss

Has the patient ever tested positive for Tuberculosis (TB) infection? ☐ Yes ☐ No

Has the patient worked, lived, spent time with, or been exposed to anyone with TB in the past two years?

☐ Yes ☐ No ☐ Not sure

Has the patient been hospitalized in the past 12 months? ☐ Yes ☐ No

If "yes," please list the approximate date, location and reason for hospitalization:

Date	**Reason**	**Location**

Has the patient had any surgeries in the past? ☐ Yes ☐ No

If "yes," please list approximate dates of surgeries:

Surgery	**Date**

Has the patient ever been diagnosed with a mental health condition? (Examples: depression, anxiety, PTSD, bipolar disorder, schizophrenia, etc.) ☐ Yes ☐ No

If "yes," please explain:

_____

_____

_____

What medications has the patient taken or been prescribed to take prior to coming to Daybreak? (include over-the-counter medications)

Medication name	**Dose**	**Frequency**	**Reason for use**	**Date started**

Is the patient taking any medications to help with their mood or thoughts not listed above?

☐ Yes ☐ No

Does the patient have any allergies? ☐ Yes ☐ No

If "yes," please explain:

Allergy **What happens if exposed?**

_____

_____

_____

Note: Please bring all medications you would like to continue at Daybreak, in their original container. We will do our best to verify and continue use while at Daybreak. If we are unable to verify, medication will need to be reordered at the discretion of Daybreak's prescribing providers. Over-the-counter medications cannot be given at Daybreak and must be reordered if deemed necessary by Daybreak providers.

Section 6: Care Provider Information

Please list the name and contact information for the patient's primary care provider

Name: _____

City/State: _____ **Phone:** _____

Other care providers/specialists:

Name: _____

City/State: _____ **Phone:** _____

Name: _____

City/State: _____ **Phone:** _____

Section 7: Insurance Information

Primary insurance carrier: _____ **Member ID number:** _____

Group number: _____ **Member services phone:** _____

Policy holder's name: _____ **Policy holder's date of birth:** _____

Policy holder's street address: _____

City: _____ **State/Province/Region:** _____ **ZIP:** _____

Secondary medical insurance (If applicable)**:**

Insurance carrier: _____ **Member ID number:** _____

Group number: _____ **Member services phone:** _____

Policy holder's name: _____ **Policy holder's date of birth:** _____

Policy holder's street address: _____

City: _____ **State/Province/Region:** _____ **ZIP:** _____

Section 8: Background & Social Information

Patient race or origin (check all that apply)**:**

☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ First Nation/Aboriginal Canadian

☐ Hispanic ☐ Native Hawaiian/ Pacific Islander ☐ Other

Does the patient have a history of physical aggression with others (fighting)? ☐ Yes ☐ No

If "yes," please explain:

_____

_____

_____

Does the patient have history of property damage/vandalism? ☐ Yes ☐ No

If "yes," please explain:

_____

_____

_____

What are the most recent substances used?

Estimate amount and frequency:

_____

_____

_____