



**216 Lake Rd
Ashburnham, MA 01430
1-800-230-8764
Fax: 978-827-4809**

Dear Applicant,

Thank you for your interest in McLean Ambulatory Treatment Center at Naukeag. We have tried to keep the admission process simple. This packet contains:

- A program description & FAQ's
- A 2 page application
- A self report medical form
- A pharmacy form
- A fax cover sheet

Referral Process

1. Read the conditions necessary for admission below. You must meet all of the admission criteria.
 - a) You are not in need of detox (will be discussed further in your phone interview)
 - b) You are medically stable to participate in the program
 - c) You are capable of participating and benefiting from the treatment milieu of 5 groups per day and an off site self-help meeting on some nights.
 - d) You are able to hold and self-administer medication, handle self-care and function independently in an open setting.
 - e) You are psychiatrically stable to live in an independent, open setting and your psychiatric disorder will not interfere with the program for you or others.
 - f) You are 18 years or older.
 - g) You can pay a night fee (if required), and co-pays on medication (fees will be discussed at time of phone interview).
2. Read the program description and FAQ sheet.
3. Fill out the 2 page application and self report medical history form as completely as possible
4. Fill out the pharmacy form
5. Using the Fax cover sheet in the packet, fax the application, medical and pharmacy form to Naukeag.
6. If you have any questions or problems call 800-230-8764 and say you need help with the application.



McLean Ambulatory Treatment Center at Naukeag Program Description and Frequently Asked Questions

Description: The Naukeag program provides Adult Short Term Residential Services for chemically dependent individuals, including those whose substance abuse is complicated by psychiatric illnesses.

Residential Treatment is for individuals who do not require the intensity and security of medical, psychiatric and nursing services offered in an inpatient program, but do require the structure of a 24-hour setting. Residential patients participate in a structured program of 5 groups/day and a self-help meeting. Patients in the residential program may be admitted from the community, or following a brief inpatient stay. **Partial Hospital Treatment** is available for individuals who need intensive treatment but do not require residential care and are able to commute to the program. Participants attend structured group therapy (3 groups) for extended blocks of days (8:30 am - 2:30 pm) spending nights at home or elsewhere. The program operates seven days a week

1. **Does the Program provide detox?**

No. All referrals must be completely detoxed and be medically cleared for ambulatory level of care prior to admission.

2. **What is the length of the Program?**

The length of stay is determined by the individual's treatment plan and insurance coverage. The average length of stay is 9-15 days, most insurance companies require pre-approval prior to admission.

3. **Are there costs beyond what my insurance pays?**

- **Medications.** You pay the pharmacy the co-pay for your medications.
- **Night Fees** Night fees vary and will be discussed during the admission interview

4. **How is the typical day structured?**

Arise at 7:00 am, breakfast. Groups are held at 9am, 11am, 1pm, 4pm and 6pm. There is a self-help meeting every evening. Free time is 2-4pm (Sunday 12-4pm) if you do not have a scheduled appointment with staff.

5. **Are there visiting hours?**

Yes, (Sunday 12-4pm).

6. **Where is Ashburnham, MA?**

Ashburnham is located in North Central Massachusetts, one hour north of Worcester, and 1½ hours northwest of Boston. The region is the Gardner/Fitchburg area.

7. **Can I smoke while at the program?**

There is no smoking in the building. Smoking is allowed outdoors during breaks and free time.

8. **Will I receive individual counseling at the program and help with aftercare placement?**

Each client is assigned an individual therapist. Individual sessions occur but the majority of treatment is conducted by group work. Each client works with the patient resource coordinator to assist with aftercare plans. Clients seeking residential treatment are referred to transitional placements or shelters due to long waiting lists at halfway houses.

9. **Can I stay longer than my insurance company allows for?**

Only if you choose to self-pay, and meet the clinical necessity to remain at this level of care. There is no ability for the program to provide free-care.

10. **Will my mental health problem be treated?**

The program provides integrated treatment. We consider both mental health and substance abuse issues to be primary. The program psychiatrist evaluates every client and prescribes medication as deemed appropriate. A pharmacy delivers medication to the program. Clients are responsible to pay for, hold and administer their own **medication**.

11. **How will I get to the Program?**

Naukeag can arrange to pick residents up at the main campus in Belmont or at the Fitchburg train station. With prearranged approval residents may drive themselves to the program. The program does not provide transportation upon discharge except to the train station.

12. **Are there any medications I cannot have at the program?**

Yes, we do not allow benzodiazepines or narcotic pain meds. Medications will be discussed during the admission interview.

13. **What should I bring to the program?**

Less is better. Bring several changes of comfortable clothing, sweaters, pajamas, (winter coat, mittens, hat) toiletries (no alcohol-based products), medications. Items such as hair dryer, iPod, reading material are acceptable. Do not bring beepers, computers, (no internet access) expensive jewelry/items or weapons of any sort. Laundry facilities are free and on-site. Linens, towels, and a lock are provided.

DEMOGRAPHIC-INSURANCE

Applicant Name: _____ DOB: _____

Address: _____

Phone number to call to set up interview _____ Cell Phone Y N

Form filled out by: _____ Phone: _____

Relationship to Applicant: Therapist/Psychiatrist PCP Family Member Other _____

Has the applicant been to Naukeag Before? N Y Date: _____

INSURANCE INFORMATION

Medicare/Medicaid Tufts Harvard Pilgrim BC\BS UBH/HPHC UBH/United Healthcare

Other: _____

Subscriber Name if different from Applicant: _____

Subscriber DOB: _____ Subscriber SS#: _____

Policy # _____

Insurance Co 800 # for MH/SA (usually on reverse side of card): _____

McLean Use Only

Medicare/Medicaid Active	Y	N	Any supplemental insurance	Y	N
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Precert Required? Y N Phone #: _____

Benefits: Partial Residential Night Fee

Comments: _____

Date/Time Sent: _____

Staff Initials: _____

Name: _____

History of Present Illness (Reason for coming to Naukeag)

Please check which drugs you have used in the past 5 years

___ Alcohol ___ Methadone ___ Marijuana ___ Hallucinogens ___ Nicotine ___ Cocaine
___ Amphetamines ___ Heroin ___ Other narcotics/pain meds (Please specify: _____
___ Benzodiazepines (Xanax, Klonopin, Valium, etc.) (Please specify: _____
___ Other (Please specify: _____

Drugs last used: _____ Date: _____

Current Drug(s) of choice: _____

Current Mental Health or Substance Abuse Providers (Please list name, agency, and phone number)

Therapist Name: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Do you have a psychiatric disorder? Yes No Diagnosis is _____

Discharge Housing Plans (please check appropriate box)

Return Home Sober House Halfway House Friends Further Residential Treatment

Other: _____

Are you currently Homeless? Yes No Do you have an emergency place to stay? Yes No

Where/Who _____ Phone _____

Do you have an aftercare plan for follow up treatment Yes No

Return to current treaters I want a therapist I want a psychiatrist IOP Partial/Day Treatment

Other program _____

MEDICAL HISTORY FORM / SELF-REPORT

Name of Patient _____ Age _____ Date _____

Name of person completing this report _____ Relationship to Patient _____

GENERAL STATE OF HEALTH Excellent Good Fair Poor

Date last seen by Primary Care Physician (PCP) _____ Date of last Physical Exam _____

Name of PCP _____ PCP Telephone Number _____

CURRENT ILLNESSES OR MEDICAL CONDITIONS _____

CURRENT PROBLEMS (Check all that apply)

- Weight loss
- Constipation
- Tremor/shakiness
- Joint/back pain
- Sleep disturbance
- Poor concentration
- Bowel problems
- Yeast infection
- Memory problems
- Loss of appetite
- Cough
- Problems with sexual functioning
- Dizziness
- Stomach pain
- Dry mouth
- Shortness of breath
- Menstrual problems
- Hemorrhoids
- Low energy
- Nausea/vomiting
- Muscle stiffness
- Headaches
- Heartburn
- Loss of sexual interest
- Diarrhea
- Weight gain
- Vision problems
- Urinary problems
- Dental problems
- Asthma/wheezing
- Blood in stool
- Hearing problems
- High blood pressure
- Sinus problems
- Chest pain
- Unwanted breast milk
- Other _____

Nutritional Assessment: Do you have any of the following problems or conditions that might affect your nutritional status?

- More than 10 lb. weight gain/loss in 3 months
- Poor food/fluid intake for more than 3 days
- New/uncontrolled diabetes mellitus
- Pregnancy
- Chewing/swallowing problems
- Eating Disorder
- HIV+/AIDS

Pain Assessment: Do you have any problems with pain?

No Yes (Describe type, intensity, quality, frequency, duration, exacerbating or relieving factors):

ALLERGIES OR DRUG REACTIONS

Drug / Allergy	Type of Reaction
_____	_____
_____	_____
_____	_____

HABITS (Amounts Used)

Alcohol _____ Drink(s) per Day
 Coffee _____ cup(s) per Day
 Smoking _____ pack(s) per Day

MEDICATIONS CURRENTLY OR FREQUENTLY TAKEN

Drug	Dose and Frequency	Drug	Dose and Frequency
_____	_____	_____	_____
_____	_____	_____	_____

PAST ILLNESSES (Check all that apply)

- Chicken pox
- Heart problems
- Bronchitis
- Urinary infections
- diabetes
- Glaucoma
- German measles
- High blood
- Pneumonia
- Kidney stones
- Thyroid problems
- Sexually transmitted Disease
- Mumps pressure
- Asthma
- Colitis
- Kidney problems
- Head injury
- Other
- Chest pain
- Cancer
- Ulcer
- Anemia
- Seizures
- Mononucleosis
- Rheumatic fever
- Stroke
- Arthritis
- Thyroid disease

PAST HOSPITALIZATIONS FOR MEDICAL PROBLEMS

Name of Hospital	City/State	Year	Illness or Operation
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY OF MEDICAL PROBLEMS (Check all that apply)

- Anemia
- Bowel problems
- Heart problems
- Ulcer
- Alcohol abuse
- Arthritis
- Colitis
- High blood pressure
- Thyroid problems
- Drug use
- Asthma or allergies
- Diverticulitis
- Diabetes
- Migraine headaches
- Other
- Bleeding problems
- Cancer or leukemia
- Gout
- Psychiatric illness
- Tuberculosis
- Stroke
- Kidney problems

FOR PHYSICIAN USE ONLY

- Does patient require a physical exam? No Yes- patient advised to schedule appointment with PCP or Internist
- Is a nutritional consult necessary? No Yes- patient advised to review with PCP or Internist
- Pain Assessment: Denies problems with pain Patient describes problems with pain - advised to review with PCP or Internist

Signature/Printed Name _____ M.D. Date _____

**McLEAN AMBULATORY TREATMENT
CENTER AT NAUKEAG**

216 Lake Road
Ashburnham, MA 01430
Tel: 978-827-5115 fax: 978-827-4809



ADMISSION FAX COVER SHEET

To: Naukeag Admissions		From:
Phone: 978-827-5115		Phone:
Fax: 978-827-4809		Fax:
Date:		Total Pages:

Urgent For Review Please Comment Please Reply

MATERIAL FAXED: Admission Packet and required documentation.

COMMENTS:

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