First Step Farm of WNC, Inc. PO Box 1450, Candler, NC 28715
Fax 828-665-5606 Women's Facility: 828-667-0303 Men's Facility: 828-665-5604

REFERRAL SOURCE SCREENING FORM (Rev. 6/09)

This form is to be completed by referring counselor and faxed to First Step Farm for review prior to setting appointment for client interview by First Step Farm staff.

CLIENT NAME: _____ DOB:_____

1. Has your client been released by a physician to perform unrestricted and strenuous farm labor with no physical limitations present? Yes ☐ No ☐

2. Does your client have current court ordered restitution payments, child support payments, alimony payments, probation/parole fees, DSS Involvment, TASC involvement? If YES, please circle all that apply. Yes ☐ No ☐

3. Is your client on or applied for disability? If yes, list type_____Yes ☐ No ☐

4. Does your client have any court appearances scheduled, outstanding charges, or unserved warrants?
If yes, list detail:_____Yes ☐ No ☐

5. Has your client ever been committed to any facility as a result of being suicidal or homicidal?
If yes, give detail:_____Yes ☐ No ☐

6. Does your client have a special diet, history of eating disorders or food allergies?
If yes, give detail:_____Yes ☐ No ☐

7. Is your client on any medication? If yes, list name of med and diagnosis_____
_____Yes ☐ No☐

8. Has your client ever been convicted of a felony or a DWI? If yes, list type of felony, number of DWI's and dates:_____Yes ☐ No ☐

9. Does your client have a psychiatric diagnosis or history of treatment for mental or emotional difficulties?
If yes, give Dx and Date given:_____Yes ☐ No ☐

10. Does your client have valid and legal identification? Yes ☐ No ☐ (NC DL, NC ID, Voter Reg, Passport, SS Card)
List two forms of legal ID for admission:_____

11. Has client ever been a resident of First Step Farm? Yes ☐ No ☐

12. Does client have a spouse, significant other, or relative in residence at First Step Farm at this time? Yes ☐ No ☐

13. Does client have any communicable diseases? Yes ☐ No ☐
If yes, check Dx and add if necessary. TB_____HIV___Hep B ___Hep C_____ Other_____

14. Is there a history of intravenous drug use? Yes ☐ No ☐ If yes, last use_____

15. Does client have legal custody of any children under age 18? Yes ☐ No ☐ If yes, is there involvement with DSS? Yes ☐ No ☐

Counselor:_____ Agency_____ Date_____