REFERRAL SOURCE SCREENING FORM

First Step Farm of WNC, Inc. **Fax 828-665-5606** **P.O. Box 1450, Candler, NC 28715**

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 involvement, TASC involvement? Yes:____ No:____ If yes, please circle all that apply.

3. Is your client on or applied for disability? Yes:____ No:____ If yes, list type: _____

4. Does your client have any court appearances scheduled, outstanding charges, or unserved warrants? Yes:____ No____ If yes list detail: _____

5. Has your client ever been committed to any facility.as a result of being suicidal or homicidal? Yes____ No____ If yes give dates starting with most recent:_____

6. Does your client have a special diet, history of eating disorders or food allergies? Yes____ No____ If yes give detail:_____

7. Is your client on any medication? Yes:____ No____ If yes, list name of medication and diagnosis:_____

_____

8. Has your client ever been convicted of a felony or a DWI? Yes:____ No____ If yes, list type of felony, number of DUI's and dates: _____

9. Does your client have a psychiatric diagnosis or history of treatment for mental or emotional difficulties? Yes____ No____ If yes, give dx and date given:_____

10. Does your client have valid and legal identification? Yes___ No___ If yes list types of identification currently in their possession: _____

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 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 of 18? Yes____ No____ If yes, is there involvement with DSS? Yes____ No____

Counselor Name & Credential: _____

Agency: _____

Phone Number: _____ Date: _____