Spring Lake Ranch
therapeutic community

1169 Spring Lake Road
Cuttingsville, VT 05738
General: 802.492.3322
Admissions: 802.772.8350
Fax: 802.492.3331
springlakeranch.org

Application for Admission

Demographic Information:

Today's Date ______________ Person Filling out Application __________________________________

Applicant's Legal Name ____
Preferred Name (if different) _____________________________
Date of Birth __ /__ /____ SSN __________________________ Gender ______________
Address ___________________________________ City ___________________ State/Zip ______________
Phone _________________________ Email____
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Race/Ethnicity:
☐ American Indian or Alaskan Native ☐ Hispanic or Latino or Spanish Origin of any race
☐ Asian ☐ Native Hawaiian or other Pacific Islander
☐ Black or African American ☐ White ☐ Other/Prefer not to say

Highest Level of Education:
☐ Some High School ☐ GED or Equivalent ☐ High School Graduate
☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree
☐ Master's Degree ☐ Doctorate Degree

Identification:
Should applicant be admitted, you will be required to provide copies of the following documentation and identification so that we will have a copy on file: 1) Insurance Cards 2) Valid Driver's License or Photo ID or Passport.

Family (please list both parents):

MOTHER OR SIGNIFICANT OTHER

Name ____
Address ____________________________________ City_____________________ State/Zip ________
Phone ______________________________ Email ____
Occupation __________________________ Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

FATHER OR SIGNIFICANT OTHER

Name ____
Address ____________________________________ City_____________________ State/Zip ________
Phone ______________________________ Email ____
Occupation __________________________ Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Please fax this completed form to 802.492.3331 (Attention: Admissions)

(1) Is there a court appointed legal Guardian, Health Care Proxy, or Power of Attorney for Medical or Financial purposes? □ Yes □ No

If yes, please fill in information below, and submit a copy of documentation for our records:

Name ____________________________ Phone ________________ Email ________________________

Address______________________________________ City__________________ State/Zip ________

(2) Referred by: _____________________________________

(3) Person financially responsible: ____

(4) Are there any current or pending legal issues or probation requirements? □ Yes (please explain) □ No

____

(5) What are your hopes for being admitted to Spring Lake Ranch?

____

____

____

(6) Other information that may be helpful in your care and treatment:

____

____

General Medical Information:

Primary Care Provider Name**:** ________________________________ City/state ________________

Phone ___________________ Fax __________________ Year PCP began seeing resident _________________

Health Insurance Co. ______________________________________ Phone ____________________

Address _______________________________________ City __________________ State/Zip ________

Policy # _________________________________ Group # ______________________________________

Policy Holder ______________________________ Policy Holder's Date of Birth ____/_____/_____

Medicare ________________________________ Medicaid ________________________________

Emergency Contacts:

(1) Name _____________________________ Relationship ___________________________

Phone ___________________ Work _______________ Email ________________________________

(2) Name _____________________________ Relationship ___________________________

Phone ___________________ Work _______________ Email ________________________________

Personal Medical History:

Medical Requirement: If the applicant has had a physical examination within the past 90 days, we will require a copy of that record. If not, it is a state licensing requirement that we schedule an appointment for a physical within 45 days of admission.

Please indicate whether applicant has had any of the following medical problems, and approximate dates:

_______ High cholesterol _______ High Blood Pressure _______ Kidney disease

_______ Diabetes _______ Thyroid problem _______ Seizure

_______ Asthma/Lung Disease _______ Head Injury _______ Lyme's disease

_______ Heart Disease (specify)______________ _______ Cancer (specify) ____________

_______ Other(specify) _____________ Major Surgeries: _____________________________________

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Allergies or reactions to medications: ____

What medical aids or devices such as glasses, CPAP, prosthesis, are you currently using?
____

Date of your most recent immunizations:
Hep A ______ Hep B ______ Influenza (flu Shot)______ MMR _____ Pneumovax (pneumonia)______
Tetanus _____ Meningitis _______ Varicella shot _______ Chicken Pox illness ____
Tdap (tetanus & pertussis) _______ Covid-19 ________

Tobacco Use
Cigarettes: □ Never □ Quit Date______ □ Current Smoker: Packs/day ___ #of yrs ________
Other Tobacco: □ Pipe □ Cigar □ Chew □ E cigarettes/vaporizer
Are you interested in quitting? □ Yes □ No

Alcohol Use
Do you drink alcohol? □ No □ Yes (Number of drinks per week) _______
When was your last drink? ___________________________________
Has your alcohol use ever been a concern for you or others? □ Yes □ No

Substance Use
Do you use any recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No
When did you last use any substances _________________

List all current prescribed medications (including psychiatric and medical):

Medication	Dose	Times per day

Medication	Dose	Times per day

List any non-prescription medicines, vitamins, remedies, birth control pills, or herbs you take:

Medication	Dose	Times per day

Medication	Dose	Times per day

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For SLR Use Only

Has SLR received all records from previous psychiatric providers? □ Yes □ No

Has SLR received all records from previous substance use providers? □ Yes □ No

FOR SLR USE ONLY

Admission Date____________________ Previous Stay______________________________

House_______________________________ HA_______________________________________

CM_________________________________ Clinician _________________________________

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