



James Fernandes, Administrative Manager
Recovery Services Division
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RECOVERY CENTER STUDENT APPLICATION

Instructions: Please complete all parts of your Student Application Packet, and fax it to James Fernandes at (617) 353- 7700 or by email jamesf19@bu.edu. After receiving your packet, he will contact before the start of the upcoming semester to arrange a tour and meeting here at the center.

PART 1: CONTACT INFORMATION

Name: _____
[Last Name] [First] [Middle Initial]

Address: _____
[Street] [Apartment/Suite Number]

[City/Town] [State] [Zip Code]

Phone: _____
[Cell] [Other]

Birthdate: _____ Preferred Pronouns: _____
[Month] [Day] [Year] [e.g. she/her/hers]

Email: _____

*Recovery Center uses email and text messaging to communicate with students. These are not secure modes of communication. By checking this box, you are agreeing to receiving emails and text messages from the center. You are accepting and understanding the risk of having your association with the center, possibly compromised with the use of unsecure email and text messages. You are also consenting to have your contact information shared with Recovery Center staff and interns, who may use it to contact you from their personal email addresses and phones.

Initials _____ Date: _____

PART 2: DEMOGRAPHIC INFORMATION

1. What is your gender identity?

- Female
- Male
- Female to male transgender (FTM)
- Male to female transgender (MTF)
- Agender
- Other (please specify): _____
- Prefer not to answer
- I don't know the answer

2. What is your race?

- Hispanic or Latino
- Black or African American
- White
- Native American or American Indian
- Asian/Pacific Islander
- Other (please specify): _____
- Prefer not to answer
- I don't know the answer

3. What is the highest degree or level of school you have completed?

- Some High School/GED
- High School Diploma/GED
- Some Undergraduate Coursework
- 2-Year College Degree (Associates)
- 4-Year College Degree (BA, BS)
- Some Graduate Coursework
- Graduate Degree (e.g. MA, MFA, PhD, MD)

4. What is your current marital status?

- Single/Never Married
- Married
- Separated
- Divorced
- Widowed
- Prefer not to answer

5. What is your current employment/ volunteer status?

- Employed Full-time (40+ hours per week)
- Employed Part-time (1-39 hours per week)
- Unemployed
- Volunteer Full-time (25+ hours a week)
- Volunteer Part-time (1-20 hours a week)

6. What is your current religious affiliation?

- Christianity
- Judaism
- Buddhism
- Islam
- Hinduism
- Agnosticism
- Unaffiliated
- Other (please specify): _____
- Prefer not to answer
- I don't know the answer

7. Military Status:

- No, Military Service
- National Guard
- Armed Forces
- Other (please specify): _____

8. Citizenship Status

- U.S Citizen by Birth (Native)
- Non-resident Visa type _____ Exp. Date: _____
- Undocumented, in process
- U.S Citizen Naturalized
- Permanent Resident

9. What is your sexual identity?

- Heterosexual, or straight
- Homosexual— gay or lesbian
- Bisexual
- Asexual
- Fluid(ity)
- Other(please specify): _____
- I don't know the answer
- Prefer not to answer

PART 3: EMERGENCY CONTACT INFORMATION

Name:	
Relationship:	
Address:	
Phone (Primary):	Phone (Secondary):
Email:	
Name:	
Relationship:	
Address:	
Phone (Primary):	Phone (Secondary):
Email:	

PART 4: PROFESSIONAL SUPPORTS

Primary Care Physician

Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):
Email:

Psychiatrist

Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):
Email:

Therapist or Counselor or Case worker
Name (Primary contact):
Counseling Service:
Address:
Phone (Primary):
Phone (Secondary):
Email:

PART 5: CURRENT MEDICAL & MENTAL HEALTH CONDITIONS

<u>Current Medical Conditions</u>	
<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Cognitive <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Breathing Problem <input type="checkbox"/> Cancer <input type="checkbox"/> Chest Pain <input type="checkbox"/> Clinical Obesity <input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetes <input type="checkbox"/> Dizziness or Fainting Spells <input type="checkbox"/> Ear Problems/Hearing Loss <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Eye Problems	<input type="checkbox"/> Heart Attack/Failure <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis _____ (A,B or C) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stomach/Intestinal Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____

Part 5: CURRENT MEDICAL & MENTAL HEALTH CONDITIONS

Current Mental Health Conditions

<input type="checkbox"/> Alcohol/Substance Abuse <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Autism Spectrum Disorder (ASD)/ Asperger's syndrome <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADHD/ADD) <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Dissociative Disorder <input type="checkbox"/> Hoarding Disorder <input type="checkbox"/> Illness Anxiety Disorder (IAD) <input type="checkbox"/> Obsessive-Compulsive Disorder (OCD)	<input type="checkbox"/> Panic Disorder <input type="checkbox"/> Personality Disorder (Borderline, Antisocial, etc.) <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD) <input type="checkbox"/> Schizophrenia/Schizoaffective disorder <input type="checkbox"/> Seasonal Affective Disorder (SAD) <input type="checkbox"/> Sexual & Paraphilic Disorder <input type="checkbox"/> Sleep & Wake Disorder (Insomnia, Narcolepsy, etc.) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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PART 6: ALLERGIES & MEDICATIONS

Allergies & Reactions

Current Medications

PART 7: INTEREST & GOALS

Please explain your interest(s) in Recovery Services at the Center:

Please explain your recovery goals and discuss what kind of help and support you think you will need to accomplish those goals:

PART 8: Authorization for Two-Way Release of Information for Medical and Psychiatric Records

1. Name of person/facility/agency other than or at Boston University to receive or release information: (insert contact relationship and name) _____
2. Information I give permission to release or receive _____
3. This release will expire on _____

If nothing is specified, it will expire when I am no longer receiving services at Boston University.

I understand that I have a right to withdraw this release at any time. If I withdraw this authorization, I must do so in writing and present it to the address above. I understand that if I pull my release of this information, it will not apply to information that has already been given before I withdrew this permission.

I understand that once the above information is disclosed to a person, facility or agency outside Boston University, the person who receives this information may disclose it again and the information may not be protected by federal or state privacy laws or regulations. I understand that I may choose whether or not to sign this form and that I do not need to sign this form in order to receive rehabilitation and recovery services from Boston University and/or the other person, facility or agency. However, without the ability to share or obtain information, Boston University and/or the other person/agency may not be able to provide effective rehabilitation and recovery services.

Your Signature or Personal Representative's Signature

Date

Print Name of Signer



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Please have your primary care physician or psychiatrist complete this form, and fax it to James Fernandes at (617) 353-7700.

MEDICAL AND PSYCHIATRIC FORM

Patient's Full Name: _____ D.O. B _____

Physician/Psychiatrist Full Name: _____

Medical Facility/Clinic/Program: _____

Date of Last Examination/Assessment: _____

Diagnoses: _____

Full DSM or ICD-10 Code(s): _____

Initial date of diagnosis: _____ Date of Last Clinical Contact: _____

Psychiatric or Other Medication(s)

Please List Any Restrictions/Recommendations:

Physician/Psychiatrist's Signature: _____ Date _____