PATIENT NAME: _____

DATE OF BIRTH: _____

Brattleboro Retreat

Child and Adolescent Residential Services

Referral Packet

We require that you directly answer all questions in this referral packet. Please do not reply "see attached" to any of the questions. We will accept additional information and documentation with the completed referral packet.

Please Submit to:

Diane Berard,
Senior Director of Access & Care Coordination
Phone: 802-258-6751
Fax: 802-258-3791
dberard@brattlebororetreat.org

Brattleboro Retreat

Client Photo

(Please attach)

REFERRAL INFORMATION

Client Name: _____

Referral date: _____

Referral Source: _____

Person making referral (include phone number and email):

Name: _____

Phone: _____

Email: _____

How long have you had the case? (If less than 6 months please provide contact information for most recent mental health practitioner or case manager):

Reason for referral and a brief description of the presenting problem (please be specific):

Psychiatric diagnoses:

Current Medications (either list below or attach medication list):

Please provide a complete medication history (either list below or attach):

Where is the patient currently receiving treatment?

When was the patient admitted to the hospital/mental health treatment facility?

Please describe the patient's behavior in the milieu:

MEDICAL INFORMATION

Medical conditions (please include current treatments):

Allergies : ☐ Yes ☐ No If yes, please specify:

Diabetes: ☐ Yes ☐ No If yes, please specify:

Traumatic Brain Injury or Concussion: ☐ Yes ☐ No If yes, please specify:

Seizure Disorder: ☐ Yes ☐ No If yes, please specify:

Recent laboratory testing results: (These may be attached.)

Patient Height: _____

Patient Weight: _____

Date of last physical: _____ Provider: _____

Date of last dental exam: _____ Provider: _____

Date of last vision exam: _____ Provider: _____

Please attach a current immunization record.

INVOLVED AGENCIES AND CURRENT PROVIDERS

Agencies involved with the patient (please check all that apply):

☐ DCF (VT) ☐ Other State DCF (Indicate State) ☐ DMH (VT) ☐ Private Practitioner

☐ Other: _____

Please provide a contact name and information for any that apply:

DCF/DCYF: _____

DMH: _____

Designated Mental Health Agency: _____

Psychiatrist: _____

Therapist: _____

PCP: _____

Case Manager: _____

Youth Services Worker: _____

Other: _____

Other: _____

CLIENT DEMOGRAPHICS

Name: _____Sex: _____

Address: _____

_____

Age: _____DOB: _____ SS#: _____

Does the patient go by a different name or nickname? If so, please specify:

What is the patient's identified gender (include his/her preferred pronoun):

What is the patient's sexual orientation:

Current Living Situation:

Is English the patient's primary language: ☐ Yes ☐ No If not, what language:

PARENT/GUARDIAN INFORMATION

Who has legal custody of the patient?

If youth is in state custody indicate the date the youth entered custody and the reason:

Are there any current conflicts or legal proceedings regarding custody of the youth? If so, please explain:

Name of parent/guardian: _____

Address: _____

Phone number (include all pertinent numbers): _____

_____

Email: _____

Is English the primary language of the parent/guardian: ☐ Yes ☐ No If no, what language:

What are the parent/guardian(s) goals for treatment?

Where is the child expected to discharge (e.g. home, a less restrictive residential program, foster care, etc.)?

If in DCF custody, what is the permanency plan?

INSURANCE INFORMATION

Insurance Name: _____

Insurance Policy Number: _____

Insurance Group Number: _____

Insurance Phone Number: ( ) _____-_____

Subscriber's Name: _____

Subscriber's Relationship to Patient: _____

Subscriber's social security number: _____-_____-_____

Subscriber's date of birth: _____

Subscriber's Employer: _____

Secondary Insurance and Policy Number (if applicable):

_____

_____

_____

CLIENT HISTORY

Suicide attempts: ☐ Yes ☐ No If yes, please report all attempts below:

Date of Attempt	Method of Attempt	Lethality/Risk Level

Suicidal Ideation: ☐ Yes ☐ No If yes, please explain nature of the suicidal thoughts, possible precipitants to thoughts, frequency, and severity of thoughts.

Cutting or other self-harm behavior: ☐ Yes ☐ No If yes, please indicate method of self-harm, if medical attention has ever been required, possible precipitants to self-harming behaviors, most recent self-harming behavior, date of last incident or if the behavior on-going.

Disordered Eating: ☐ Yes ☐ No If yes, please indicate the type of disordered eating (binge eating, purging, restricting intake, etc), when it began, and how frequently it occurs.

Has the client ever been hospitalized for treatment of or medical complications from an eating disorder? If so, please explain:

Homicidal Ideation: ☐ Yes ☐ No If yes, please explain:

Physical Aggression: ☐ Yes ☐ No If yes, please explain:

Has the client ever engaged in aggressive behavior that resulted in serious injury to another person: ☐ Yes ☐ No If yes, please explain:

Has the client ever used a weapon against another person (e.g. firearms, knife)?
☐ Yes ☐ No If yes, please explain:

Verbal Abuse: ☐ Yes ☐ No If yes, please explain:

Fire Setting: ☐ Yes ☐ No If yes, please explain:

Has the patient intentionally set a fire that caused damage within the past 6 months:
☐ Yes ☐ No If yes, please explain:

Has the patient ever set a fire resulting in the injury of people: ☐ Yes ☐ No If yes, please explain:

Has the patient ever had a fire-setting evaluation or risk assessment? ☐ Yes ☐ No If yes, please attach.

Cruelty to Animals: ☐ Yes ☐ No If yes, please explain:

Property Destruction: ☐ Yes ☐ No If yes, please explain:

Sexually Reactive: ☐ Yes ☐ No If yes, please explain:

Has the patient engaged in sex offending behavior or been convicted of a sexual offense:
☐ Yes ☐ No If yes, please explain:

Has the patient had a psychosexual or sexual offending evaluation or risk assessment:
☐ Yes ☐ No If yes, please attach.

Inappropriateness with Younger Children: ☐ Yes ☐ No If yes, please explain:

Juvenile Justice System Involvement: ☐ Yes ☐ No If yes, please explain:

Has the youth experienced any type of abuse or neglect: ☐ Yes ☐ No If yes, please explain:

☐ Physical _____

☐ Sexual _____

☐ Verbal _____

☐ Witness to Domestic Violence _____

☐ Traumatic loss (e.g. death of a parent) _____

☐ One-time major traumatic event (e.g. house fire, car accident) _____

☐ Neglect _____

☐ Other _____

Running Away: ☐ Yes ☐ No If yes, please explain:

Sexually Active: ☐ Yes ☐ No If yes, please explain:

Substance Abuse:

Has the patient ever used mood-altering substance? : ☐ Yes ☐ No

If yes, please complete the following: What mood-altering substances has the patient used?

- ☐ Cigarettes/Tobacco
- ☐ Alcohol
- ☐ Cannabis
- ☐ Stimulants or "uppers" (e.g. amphetamine, meth)
- ☐ Sedatives or "downers" (e.g. benzodiazepines)
- ☐ Opiates (e.g. morphine, heroin, OxyContin)
- ☐ Inhalants
- ☐ Hallucinogens
- ☐ Misuse of prescribed Medication: _____ _____
- ☐ Other: _____ _____

Has the patient ever been treated for substance-abuse? If so, in what treatment setting (residential treatment, intensive outpatient, individual counseling)?

For each substance the patient has used, please fill out the following:

Substance (in order of "preference")	**Age of First Use**	**One-Time Use Only?**	**Current Frequency of Use**	**Amount Used Per Using Episode**	**Negative Consequences of Use**	**Stage of Change** (Pre-contemplation, contemplation, preparation, action, maintenance, relapse)

Compliant with medication: ☐ Yes ☐ No If no, please explain:

Special Dietary Needs: ☐ Yes ☐ No If yes, please explain:

Sleep Disturbance: ☐ Yes ☐ No If yes, please explain:

Enuresis or Encopresis: ☐ Yes ☐ No If yes, please explain:

Does the patient need assistance in carrying out activities of daily living (for example, feeding themself, bathing, grooming, or toileting)? : ☐ Yes ☐ No If yes, please explain:

Physical or Mobility Impairments: ☐ Yes ☐ No If yes, please explain:

Developmental Disability or Intellectual Disability: ☐ Yes ☐ No If Yes, what is client's IQ? ___
If yes, please explain:

******Psychological Testing Results/IQ Testing results: If available please attach results from any psychological testing and or IQ testing results******

PREVIOUS TREATMENT

Outpatient Services (include information such as provider, length of time in treatment):

Psychiatric Hospitalizations (include information such as date(s), reasons for admission, length of stay, and where):

Other Treatment Settings (include date(s), reason for admission, length of stay, program name, level of care (ie: IFBS, PHP, IOP, etc.), and outcome of treatment):

OTHER INFORMATION

In the space below feel free to provide any additional comments or concluding thoughts that should be considered when this referral is reviewed:

Please attach any additional documentation that may be helpful such as a psychosocial history assessment, psychiatric testing, and mental health evaluations/assessments.

EDUCATIONAL REFERRAL INFORMATION

(ALL RESIDENTS ATTEND BRATTLEBORO RETREAT MEADOWS SCHOOL)

Name: _____Sex: _____

Address: _____

_____

Age: _____DOB: _____ SS#: _____

Does the student go by a different name or nickname? If so, please specify:

What is the student's identified gender (include his/her preferred pronoun):

What is the student's sexual orientation:

Is English the student's primary language: ☐ Yes ☐ No If not, what language:

Who has legal custody of the student?

Name of parent/guardian: _____

Address: _____

Phone number (include all pertinent numbers): _____

_____

Email: _____

Is English the primary language of the parent/guardian: ☐ Yes ☐ No If no, what language:

Where is the student expected to discharge (e.g. home, a less restrictive program, foster care, etc.)?

Has the student graduated from high school or obtained a GED? ☐ Yes ☐ No

Name of school district: _____Grade: _____

Does the student have an IEP? ☐ Yes ☐ No If yes, please attach

Does the student have a 504 plan? ☐ Yes ☐ No If yes, please attach

School contact name and phone number:

Name:_____

Phone:_____

Is the student currently attending school?

Brief description of presenting problem as it may relate to the classroom (i.e. safety related behaviors, medical concerns).