Brattleboro Retreat

Patient Name: _____

Date of Birth: _____

Child and Adolescent Residential Services

Referral Packet

- Please do not reply. See attached questions. We require that you directly answer all questions in this referral packet. We will accept additional information, but that alone will not suffice as a completed referral.
- Please submit to:

Michele L. Noel
Director of Managed Care Contracting and Utilization Management
Phone: 802-258-6155
Fax: 802-258-3742
mnoel@brattlebororetreat.org

Section A: REFERRAL INFORMATION

Patient Name: _____

Referral Date: _____

Referral Source: _____

Person making referral (include phone number and email):

Name: _____

Phone: _____

Email: _____

1. **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):**

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

3. **Psychiatric diagnoses:**

4. **Current Medications (either list below or attach medication list):**

5. **Please provide a complete medication history:**

6. **Medical conditions (please include current treatments):**

7. **Allergies (please specify):**

8. **Recent laboratory testing results (these may be attached):**

SECTION B: Client/Case Background

1. **Where is the youth currently receiving treatment?**

2. **When was the youth admitted to the hospital/mental health treatment facility?**

3. **Please describe the youth's behavior in the milieu:**

INVOLVED AGENCIES AND/OR CURRENT PROVIDERS (IF NOT ALREADY LISTED)

Other agencies involved with the youth (please check all that apply):

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

☐ Other: _____

Please provide name and contact information for any of the following that apply:

DCF/DCYF: _____

DMH: _____

Designated Mental Health Agency: _____

Psychiatrist: _____

Therapist: _____

Primary Care Provider: _____

Case Manager: _____

Youth Services Worker: _____

Other: _____

Other: _____

SECTION C: Client Demographics (please supply all requested information)

Name: _____ **Gender:** _____

Address: _____

_____

Age: _____ **DOB:** _____ **SS#:** _____

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: _____

SECTION D: Parent/Guardian Demographics

Who has legal custody of the youth?

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

Name of parent/guardian: _____

Address: _____

Phone number(s) (include all pertinent numbers): _____

_____

Email Address: _____

Is English the primary language: ☐ Yes ☐ No If no, what language:

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

_____

_____

_____

SECTION E: 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):

_____

SECTION F: Client History

Suicide attempts: ☐ Yes ☐ No

If yes, please indicate number of attempts, method of attempt(s), lethality, risk level, and dates attempted.

Suicidal Ideation: ☐ Yes ☐ No

If yes, please explain nature of the suicidal thoughts, possible precipitants to thoughts, frequency, and severity of thoughts.

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

Cutting or other self-harm ☐ Yes ☐ No

If yes, please indicate if medical attention has ever been required, possible precipitants to self-harming behaviors, most recent self-harming behavior, last incident, or if the behavior is on-going.

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

Cruelty to animals: ☐ Yes ☐ No (If yes, please explain):

Substance abuse: ☐ Yes ☐ No (If yes, please explain):

Running away: ☐ Yes ☐ No (If yes, please explain):

Physical aggression: ☐ Yes ☐ No (If yes, please explain):

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

Inappropriate behavior with younger children: ☐ Yes ☐ No (If yes, please explain):

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

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

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

Any special dietary needs: ☐ Yes ☐ No If yes, please explain:

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

Is patient a Victim of abuse: ☐ Physical ☐ Sexual ☐ Verbal ☐ No
(If yes, please explain):

Legal Involvement: ☐ Yes ☐ No (If yes, please explain):

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

SECTION G: Previous Treatment

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

Psychiatric hospitalizations (include information such as number of admissions, reasons for admission and where):

Other treatment settings (include the following: what level of care (ie: IFBS, PHP, IOP, etc.) where, reason for admission, length of stay, and outcome (i.e., did the patient complete the program or was it considered a failed attempt at that level of care?).

SECTION H: Educational Information

Name of school district: _____ Grade: _____

IEP/504: ☐ Yes ☐ No Specify which:

School contact name and phone number:

Name: _____

Phone: _____

Is the youth currently attending school? ☐ Yes ☐ No

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