Fax completed form to 802-258-3791

Brattleboro Retreat

Phone: 802-258-3700

Referral Date: _____

External Provider Referral Form

☐ **Inpatient** ☐ **PHP** ☐ **Starting Now (IOP)** ☐ **HUB (MAT)** ☐ **Outpatient Counseling**

PATIENT NAME: _____ DOB: _____ SS#: _____

Address: _____ Tel. #: _____

REFERRED BY: _____ E-mail _____

Practice Name: _____ Contact Tel. #: _____

INSURANCE: _____ **SUBSCRIBER NAME**: _____

Subscriber DOB: _____ Insurance ID #: _____ Tel. #: _____

Subscriber's relationship to patient: ☐ spouse ☐ parent ☐ self

Current Symptoms & Behaviors:

1.

2.

3.

4.

Diagnoses (psychiatric & medical):

1.

2.

3.

4.

Patient History (check all boxes that apply)

1. Suicidal/Homicidal Ideation:	☐ **yes**	☐ **no**	☐ **current**	☐ **past**
2. Violence history:	☐ **yes**	☐ **no**	☐ **current**	☐ **past**
3. Legal issues:	☐ **yes**	☐ **no**	☐ **current**	☐ **past**

Substance Abuse History:

Drug (check all that apply)	Amount Used	Frequency of use	Date of Last Use
Alcohol ☐			
Benzodiazepines ☐			
Heroin ☐			
Opioids ☐			
Marijuana ☐			
Stimulants ☐			
Other: _____			

Continued….

Is client aware you are making this referral? ☐ **yes** ☐ **no**

Treatment Provider Contacts:

	Name	Address	Phone number
Physician/PCP			
Psychiatrist			
Therapist			
Case Manager			
Suboxone Provider			
Methadone Provider			

Please List Patient's Current Medications (or attach list):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

- **Please attach a copy of the patient's most recent assessment.**
- **All inpatient referrals from ERs require H&P and LABS to be attached.**

Notes: