Form last updated 02/03/2023

All Inpatient Referrals from ERs Require H&P and LABS to be attached.

Brattleboro Retreat
MENTAL HEALTH AND ADDICTION CARE

Referral Date: ___________________

EXTERNAL PROVIDER REFERRAL FORM

Fax this completed form to 802-258-3791.

Referred by:___________________________________**Email:** _______________________________

Practice Name:_________________________________**Contact Tel. #** _________________________

I am referring this patient for services in the following Retreat program(s) (circle those that apply) :

Inpatient **Partial Hospital Program** **Intensive Outpatient Program**

Outpatient Psychotherapy **Healthcare Professionals & First Responders PHP/IOP**

PATIENT'S NAME:_____________________________________**PATIENT'S PRONOUNS:** ______________

PATIENT'S ADDRESS: ____

PATIENT'S E-Mail:____________________________________**Patient's Phone**: ______________________

PATIENT'S D/O/B:____________________________________**Patient's SS#:** ________________________

HEALTH INSURANCE CARRIER: ____

SUBSCRIBER's NAME:__________________________________**SUBSCRIBER D/O/B**: __________________

INSURANCE ID #:___________________________**INSURANCE Tel. #**: ______________________________

Subscriber's relationship to patient (circle): self spouse parent

Presenting Problem(s): Briefly describe the patient's presenting problem(s) and most recent helpful intervention(s):

____

____

____

____

Is this something recent? Yes No

(If yes) when did this problem start: ____

What are the GOALS for treatment? ____

____

Does patient have access to technology (computer, internet service, etc.) that would allow participation in a remote treatment program using Zoom?______yes_______no

Is the person experiencing any of the following?

- **Depression:** ☐Yes ☐No ☐Past
- **Anxiety:** ☐Yes ☐No ☐Past
- **Trauma/PTSD:** ☐Yes ☐No ☐Past
- **Psychosis:** ☐Yes ☐No ☐Past
- **OCD:** ☐Yes ☐No ☐Past
- **ADHD:** ☐Yes ☐No ☐Past
- **Other:** ______________________________

DIAGNOSES (Psychiatric, Medical, Substance Use, Other)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

PATIENT HISTORY—Is the person experiencing/reporting any of the following?

- **Suicidal Ideation:** ☐Yes ☐No ☐Current ☐Past
- **Self-Injurious Behavior:** ☐Yes ☐No ☐Current ☐Past
- **Homicidal ideation:** ☐Yes ☐No ☐Current ☐Past
- **Violence history:** ☐Yes ☐ No ☐Current ☐Past

ANY OTHER CURRENT SYMPTOMS/BEHAVIORS THAT ARE IMPORTANT FOR US TO KNOW?

- ______________________________
- ______________________________

SUBSTANCE USE: Is the person using tobacco, cannabis, alcohol, or illicit drugs? ☐Yes ☐No (List)

1. Primary DOC:__________Age first use_____Last Use______Amount______
   Comment______________________________
2. Secondary DOC:__________Age first use_____Last Use______Amount______
   Comment______________________________
3. Tertiary DOC:__________Age first use_____Last Use______Amount______
   Comment______________________________

Tobacco: ☐Yes ☐No
Opioids/Opiates (MAT): ☐Yes ☐No If Yes, (☐Buprenorphine ☐Methadone ☐Naltraxone)
Alcohol (MAT): ☐Yes ☐No If Yes, (☐ Antibuse, ☐ Campral,
☐Naltraxone/Vivitrol)

MEDICATIONS—If the person is currently taking any medications, please list them here:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

FUNCTIONALITY: **Are this person's presenting problem interfering with ADLs and IADL's?**
(Check all that apply):

____**Basic Communication**
____**Transportation**
____**Meal Prep**
____**Shopping**
____**Housework**
____**Managing Medication**
____**Managing Personal Finances**
____**Personal Hygiene**
____**Dressing**
____**Eating**
____**Maintaining Continence**
____**Transferring/Mobility**

- **Any Comments Regarding Patient's Functionality?**

  ____
  ____
  ____
  ____
  ____

HISTORY OF RECENT TREATMENTS: ☐ **Yes** ☐ **No** **(If yes, please list):**

- ____
- ____

WHO are the PATIENT'S CURRENT TREATMENT PROVIDERS?

PHYSICIAN/PRIMARY CARE: ____
ADDRESS:____
PHONE:______________________FAX #: ______________________

THERAPIST/COUNSELOR:____
ADDRESS:____
PHONE:______________________FAX #: ______________________

PSYCHIATRIST:____
ADDRESS:____
PHONE:______________________FAX #: ______________________

CASE MANAGER: ____
ADDRESS:____
PHONE:______________________FAX #: ______________________

M.A.T. PROVIDER (if applicable): ____
ADDRESS:____
PHONE:______________________FAX #: ______________________

MH/SU/Other Organization: ____
ADDRESS:____
PHONE:______________________FAX #: ______________________

Optional SELF-SUFFICIENCY MATRIX

The following self-assessment tool is for individuals who wish to determine their own strengths and areas for improvement. (Completed by client/patient or with provider).

- FOOD ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- HOUSING ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- INCOME ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- PERSONAL SAFETY ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- TRANSPORTATION ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- ABILITY to FUNCTION ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- CRIMINAL JUSTICE SYSTEM ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- LEGAL SYSTEM (non-criminal) ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- MONEY/FINANCES ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- SUPPORT SYSTEM ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- SUBSTANCE USE ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- PHYSICAL HEALTH ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- MENTAL HEALTH ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- EMPLOYMENT ☐ In crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving

DO ANY OF THE FOLLOWING RELATE to The PATIENT'S CURRENT LIFE SITUATION?

If yes, please check the appropriate box beside each category:

- Employment ☐ In Crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- Adult Education ☐ In Crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- Child Education ☐ In Crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- Child Care ☐ In Crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving
- Parenting Skills ☐ In Crisis ☐ Vulnerable ☐ Safe ☐ Stable ☐ Thriving

COMMENTS:

____

____

____

____

Please be sure to attach a copy of the Patient's Most Recent Assessment.

CLIENT DEMOGRAPHICS

Client Race

Check the boxes that most accurately describe your race:

- ☐ American Indian or Alaskan Native
- ☐ Asian Indian
- ☐ Black or African-American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Refused

Ethnic Origin

Check the boxes that most accurately describe you ethic origin:

- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ Yes, Puerto Rican
- ☐ Yes, Other Hispanic Origin
- ☐ No, Not Hispanic, Latino/a or Spanish
- ☐ Refused

Primary Language

What is your primary language?:

- ☐ American Sign Language
- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ German
- ☐ Hindi/Indic languages
- ☐ Italian
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other