Form last updated 10/7/2021

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** **Spoke MAT**

Outpatient Psychotherapy **Uniformed Service Program**

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