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.