HELP FOR HEROES

Referral Form

Please Select the Program(s) Recommended:

Inpatient *Anticipated Start Date:* _____

☐ Trauma	☐ Addiction	☐ Mental Health	☐ Crisis Stabilization
Combat Trauma	SUD	Adjustment	Abbreviated Treatment
Complex Trauma	Process Addict	Suicidal/Homicidal	Acute Crisis
Survivors Guilt	Co-Occurring	Childhood Abuse	Other
MST	Detox	Gen. MH	
Other	Other	Other	

☐ **Women's Inpatient Program - *Site Specific**

*Select track(s) from above

Outpatient *Anticipated Start Date:* _____

☐ **PHP** ☐ **IOP**

Clinical Information:

Diagnosis(es):

Medical Conditions and Other Pertinent Info:

Presenting Concern:

Please attach and fax current medications and other pertinent clinical information on patient

Pending Military UCMJ/Legal?: Yes ☐ No ☐

Transportation requested? Yes ☐ No ☐

Transportation may be requested as part of treatment to ensure that service members receive care as quickly and safely as possible for this specialty service. The service member will be returned back to referring provider at a time and date mutually agreed upon by facility and referring provider.

Patient Demographics:

Name:

DOB:

Phone Number:

Duty Station:

Branch/Rank:

MOS/Job Title:

WEEKLY UPDATE CONTACTS:

Base Behavioral Health Provider
Name
Contact Phone Number
Contact Fax Number
Email
Base Nurse Case Manager Provider
Name
Contact Phone Number
Contact Fax Number
Email
Command Contact
Name
Contact Phone Number

_____ ___/___/___

Referring Provider Signature **Date**

ONE CALL DOES IT ALL

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