HELP FOR HEROES

Service Member Referral Form

Please Select Level of Care & Program Track(s):

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 - Rock Springs - Georgetown, TX
*Select track(s) from above

Outpatient Anticipated Start Date: _____

☐ PHP ☐ IOP ☐ VIOP

Clinical Information:

*Please attach/fax recent Psych Eval, mental health progress notes, current medications and other pertinent medical records

Diagnosis(es): _____

_____

Medical Conditions and Other Pertinent Info: _____

_____

_____

Presenting Concern: _____

_____

_____

Pending Military UCMJ/Legal?: Yes ☐ No ☐

Command Contact
Name(s)
Contact Phone Number(s)

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.

_____ _____

Referring Provider Signature Date

Patient Demographics:

Name: _____

DOB: _____

SSN: _____

Gender: _____

Phone Number: _____

Duty Station/Unit: _____

Branch: _____

Status: _____

Rank: _____

TRICARE AUTHORIZATION SUBMITTED?
Yes ☐ No ☐

Weekly Clinical Update Contacts:

On-Call/After Hours Clinic Number: _____

Base Behavioral Health Provider
Name
Phone
Fax
Email

Base Nurse Case Manager
Name
Phone
Fax
Email

Additional Contact (title):
Name
Phone
Fax
Email