

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_



# Brattleboro Retreat

## **Child and Adolescent Residential Services Referral Packet**

**\*\*We require that you directly answer all questions in this referral packet. Please do not reply “see attached” to any of the questions. We will accept additional information and documentation with the completed referral packet.\*\***

Please Submit to:

Michele L. Noel,  
Director of Utilization Management  
Phone: 802-258-6155  
Fax: 802-258-3742  
[mnoel@brattlebororetreat.org](mailto:mnoel@brattlebororetreat.org)



# Brattleboro Retreat

Client Photo  
(Please attach)

## REFERRAL INFORMATION

Client Name: \_\_\_\_\_

Referral date: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Person making referral (include phone number and email):

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

How long have you had the case? (If less than 6 months please provide contact information for most recent mental health practitioner or case manager):

Reason for referral and a brief description of the presenting problem (please be specific):

Psychiatric diagnoses:

Current Medications (either list below or attach medication list):

Please provide a complete medication history (either list below or attach):

Where is the patient currently receiving treatment?

When was the patient admitted to the hospital/mental health treatment facility?

Please describe the patient's behavior in the milieu:

**MEDICAL INFORMATION**

Medical conditions (please include current treatments):

Allergies :  Yes  No If yes, please specify:

Diabetes:  Yes  No If yes, please specify:

Traumatic Brain Injury or Concussion:  Yes  No If yes, please specify:

Seizure Disorder:  Yes  No If yes, please specify:

Recent laboratory testing results: (These may be attached.)

Patient Height: \_\_\_\_\_

Patient Weight: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Provider: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ Provider: \_\_\_\_\_

Date of last vision exam: \_\_\_\_\_ Provider: \_\_\_\_\_

Please attach a current immunization record.

**INVOLVED AGENCIES AND CURRENT PROVIDERS**

Agencies involved with the patient (please check all that apply):

DCF (VT)     Other State DCF (Indicate State)     DMH (VT)     Private Practitioner

Other: \_\_\_\_\_

Please provide a contact name and information for any that apply:

DCF/DCYF: \_\_\_\_\_

DMH: \_\_\_\_\_

Designated Mental Health Agency: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

Therapist: \_\_\_\_\_

PCP: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Youth Services Worker: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

**CLIENT DEMOGRAPHICS**

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Does the patient go by a different name or nickname? If so, please specify:

What is the patient's identified gender (include his/her preferred pronoun):

What is the patient's sexual orientation:

Current Living Situation:

Is English the patient's primary language:  Yes  No If not, what language:

**PARENT/GUARDIAN INFORMATION**

Who has legal custody of the patient?

If youth is in state custody indicate the date the youth entered custody and the reason:

Are there any current conflicts or legal proceedings regarding custody of the youth? If so, please explain:

Name of parent/guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number (include all pertinent numbers): \_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

Is English the primary language of the parent/guardian:  Yes  No If no, what language:

What are the parent/guardian(s) goals for treatment?

Where is the child expected to discharge (e.g. home, a less restrictive residential program, foster care, etc.)?

If in DCF custody, what is the permanency plan?

**INSURANCE INFORMATION**

Insurance Name: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Insurance Group Number: \_\_\_\_\_

Insurance Phone Number: (        ) \_\_\_\_\_ - \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Relationship to Patient: \_\_\_\_\_

Subscriber's social security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Subscriber's date of birth: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Secondary Insurance and Policy Number (if applicable):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CLIENT HISTORY

**Suicide attempts:**  Yes  No If yes, please report all attempts below:

Date of Attempt	Method of Attempt	Lethality/Risk Level

**Suicidal Ideation:**  Yes  No If yes, please explain nature of the suicidal thoughts, possible precipitants to thoughts, frequency, and severity of thoughts.

**Cutting or other self-harm behavior:**  Yes  No If yes, please indicate method of self-harm, if medical attention has ever been required, possible precipitants to self-harming behaviors, most recent self-harming behavior, date of last incident or if the behavior on-going.

**Disordered Eating:**  Yes  No If yes, please indicate the type of disordered eating (binge eating, purging, restricting intake, etc), when it began, and how frequently it occurs.

Has the client ever been hospitalized for treatment of or medical complications from an eating disorder? If so, please explain:

**Homicidal Ideation:**  Yes  No If yes, please explain:

**Physical Aggression:**  Yes  No If yes, please explain:



Has the client ever engaged in aggressive behavior that resulted in serious injury to another person:  Yes  No If yes, please explain:

Has the client ever used a weapon against another person (e.g. firearms, knife)?  
 Yes  No If yes, please explain:

**Verbal Abuse:**  Yes  No If yes, please explain:

**Fire Setting:**  Yes  No If yes, please explain:

Has the patient intentionally set a fire that caused damage within the past 6 months:  
 Yes  No If yes, please explain:

Has the patient ever set a fire resulting in the injury of people:  Yes  No If yes, please explain:

Has the patient ever had a fire-setting evaluation or risk assessment?  Yes  No If yes, please attach.

**Cruelty to Animals:**  Yes  No If yes, please explain:

**Property Destruction:**  Yes  No If yes, please explain:

**Sexually Reactive:**  Yes  No If yes, please explain:

Has the patient engaged in sex offending behavior or been convicted of a sexual offense:  
 Yes  No If yes, please explain:

Has the patient had a psychosexual or sexual offending evaluation or risk assessment:  
 Yes  No If yes, please attach.

**Inappropriateness with Younger Children:**  Yes  No If yes, please explain:

**Juvenile Justice System Involvement:**  Yes  No If yes, please explain:

**Has the youth experienced any type of abuse or neglect:**  Yes  No If yes, please explain:

- Physical \_\_\_\_\_
- Sexual \_\_\_\_\_
- Verbal \_\_\_\_\_
- Witness to Domestic Violence \_\_\_\_\_
- Traumatic loss (e.g. death of a parent) \_\_\_\_\_
- One-time major traumatic event (e.g. house fire, car accident) \_\_\_\_\_
- Neglect \_\_\_\_\_
- Other \_\_\_\_\_

**Running Away:**  Yes  No If yes, please explain:

**Sexually Active:**  Yes  No If yes, please explain:

**Substance Abuse:**

Has the patient ever used mood-altering substance? :  Yes  No

If yes, please complete the following: What mood-altering substances has the patient used?

- |  |   |
|--|---|
| <input type="checkbox"/> Cigarettes/Tobacco                              | <input type="checkbox"/> Opiates (e.g. morphine, heroin, OxyContin) |
| <input type="checkbox"/> Alcohol   | <input type="checkbox"/> Inhalants                                  |
| <input type="checkbox"/> Cannabis  | <input type="checkbox"/> Hallucinogens                              |
| <input type="checkbox"/> Stimulants or "uppers" (e.g. amphetamine, meth) | <input type="checkbox"/> Misuse of prescribed Medication: _____     |
| <input type="checkbox"/> Sedatives or "downers" (e.g. benzodiazepines)   | _____   |
|  | <input type="checkbox"/> Other: _____                               |
|  | _____   |

Has the patient ever been treated for substance-abuse? If so, in what treatment setting (residential treatment, intensive outpatient, individual counseling)?

For each substance the patient has used, please fill out the following:

<b>Substance</b> (in order of "preference")	<b>Age of First Use</b>	<b>One-Time Use Only?</b>	<b>Current Frequency of Use</b>	<b>Amount Used Per Using Episode</b>	<b>Negative Consequences of Use</b>	<b>Stage of Change</b> (Pre-contemplation, contemplation, preparation, action, maintenance, relapse)

**Compliant with medication:**  Yes  No If no, please explain:

**Special Dietary Needs:**  Yes  No If yes, please explain:

**Sleep Disturbance:**  Yes  No If yes, please explain:

**Enuresis or Encopresis:**  Yes  No If yes, please explain:

**Does the patient need assistance in carrying out activities of daily living** (for example, feeding themselves, bathing, grooming, or toileting)? :  Yes  No If yes, please explain:

**Physical or Mobility Impairments:**  Yes  No If yes, please explain:

**Developmental Disability or Intellectual Disability:**  Yes  No If Yes, what is client's IQ? \_\_\_\_  
If yes, please explain:

**\*\*\*\*Psychological Testing Results/IQ Testing results: If available please attach results from any psychological testing and or IQ testing results\*\*\*\***

### **PREVIOUS TREATMENT**

**Outpatient Services** (include information such as provider, length of time in treatment):

**Psychiatric Hospitalizations** (include information such as date(s), reasons for admission, length of stay, and where):

**Other Treatment Settings** (include date(s), reason for admission, length of stay, program name, level of care (ie: IFBS, PHP, IOP, etc.), and outcome of treatment):

### **OTHER INFORMATION**

In the space below feel free to provide any additional comments or concluding thoughts that should be considered when this referral is reviewed:

Please attach any additional documentation that may be helpful such as a psychosocial history assessment, psychiatric testing, and mental health evaluations/assessments.

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**EDUCATIONAL REFERRAL INFORMATION**  
*(ALL RESIDENTS ATTEND BRATTLEBORO RETREAT MEADOWS SCHOOL)*

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Does the student go by a different name or nickname? If so, please specify:

What is the student's identified gender (include his/her preferred pronoun):

What is the student's sexual orientation:

Is English the student's primary language:  Yes  No If not, what language:

Who has legal custody of the student?

Name of parent/guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number (include all pertinent numbers): \_\_\_\_\_

Email: \_\_\_\_\_

Is English the primary language of the parent/guardian:  Yes  No If no, what language:

Where is the student expected to discharge (e.g. home, a less restrictive program, foster care, etc.)?

Has the student graduated from high school or obtained a GED?  Yes  No

Name of school district: \_\_\_\_\_ Grade: \_\_\_\_\_

Does the student have an IEP?  Yes  No If yes, please attach

Does the student have a 504 plan?  Yes  No If yes, please attach

School contact name and phone number:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Is the student currently attending school?

Brief description of presenting problem as it may relate to the classroom (i.e. safety related behaviors, medical concerns).

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