



100 Gould Road, P.O. Box 157
www.gouldfarm.org

Monterey MA 01245-0157
Phone: 413-528-1804 Fax: 413-645-1022

Psychiatric Referral Form

Name of applicant _____ Date _____

Address _____

City _____ State _____ Zip _____

Reliable phone number: _____ *check* ___ cell ___ home ___ other _____

Marital status _____ SS# _____ Date of birth _____

Medical Insurance: Medicare _____ Medicaid _____

Private Carrier _____ Policy# _____

Current Medication Schedule

	<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Emergency P.R.N. Medication (**must** be indicated) _____

How long has applicant been on present medication? _____

Medical Profile

(responses to be typed on a separate sheet)

- A. General medical history
- B. History of any alcoholism and/or drug addiction
- C. Physical activities applicant should avoid
- D. Allergic or other reactions to psychotropic, antibiotic or other drugs

Psychiatric Profile

(responses to be typed on a separate sheet)

- A. Diagnosis _____ Prognosis _____
- B. Submit a detailed, current psychiatric evaluation of the patient, including your personal judgment as to whether the applicant is suicidal, homicidal, or in any way inclined to be destructive toward him/herself or others.
- C. Submit a detailed psychiatric history. Have the patient sign and send authorization to all agencies from whom care has been received so summaries can be sent directly to us.
- D. Please state clearly the applicant's present place of residence and life situation; whether employed or in school or how otherwise using his/her time; the highest level of education attained; why his/her present living situation is not satisfactory or not adequate.
- E. List primary goals the applicant wishes to achieve.
- F. Is the applicant able to be responsible for his/her own behavior and safety in an open rural environment; able to fully care for his/her personal hygiene needs and laundry without staff prodding; fully able and motivated to meet all program requirements; able to refrain from use of alcohol and illicit drugs altogether; able to confine smoking to designated areas; able to function relatively independently without close surveillance? Yes____No____. If the answer to any of these questions is no, please explain in detail on a separate sheet.
- G. Suggested length of stay ____ up to 6 months ____ 6-12 months ____ more than 12 months

Treating Psychiatrist _____ Date _____

Print name clearly

Address _____ City _____ State _____ Zip _____

Phone _____ Signature _____

Referral Coordinator (include title) _____ Phone _____

Address _____

I understand the requirements/expectations of applying for/joining Gould Farm's program.

Applicant _____ Date _____

Signature

Responsible Party Contracting with Gould Farm: _____

Relationship to Applicant _____ Phone _____