GOULD FARM
Harvesting Hope ◆ Promoting Recovery

Please send completed form to:
Tamara McKernan, Director of Admissions
100 Gould Road, P.O. Box 157
Monterey, MA 01245
P: 413.528.1804 F: 413.645.1022
admissions@gouldfarm.org

Treatment Provider Referral Form

Name of applicant Date

Address

City State Zip

Phone number Cell number

Marital Status SS# DOB

Current Medication Schedule

Please complete table below or attach a copy of the appropriate paperwork.

Medication	Dosage	Frequency

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

How long has applicant been on present medication?

Medical Profile

(Please type responses on a seperate sheet or attach appropriate paperwork)

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

(Please type responses on a seperate sheet or attach appropriate paperwork)

A.) Diagnosis Prognosis

B.) Submit a detailed, current psychiatric evaluation of the applicant, including your personal judgement as to whether the applicant is suicidal, homicidal, or in any way inclined to be destructive toward themselves or others.

C.) Submit a detailed psychiatric history. Have the applicant 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 their time; the highest level of education attained; why their present living situation is not satisfactory or not adequate.

E.) List primary goals the applicant wishes to achieve.

F.) Based on your assessment, is the applicant able to:

be responsible for their own behavior and safety in an open rural environment?	☐ Yes	☐ No
care for their own personal hygiene needs and laundry with minimal assistance?	☐ Yes	☐ No
and motivated to participate in the program?	☐ Yes	☐ No
refrain from use of alcohol and ilicit drugs altogether?	☐ Yes	☐ No
confine smoking to designated areas?	☐ Yes	☐ No
function relatively independently without close surveillance?	☐ Yes	☐ No

If the answer to any of these questions is No please explain below:

G.) Suggested length of stay ☐ up to 6 months ☐ 6 to 12 months ☐ greater than 12 months

Treatment Provider Date-

Address Email

City State Zip

Phone number **Signature**

Referral Coordinator/Title Phone number

Address Email