

Warrior Combat Stress Reset Program (WCSRP) Patient Referral Form

Referral Source

Referring Provider: _____		Date of Referral: _____	
Department/Clinic: _____		Facility Name/Location: _____	
Referring Provider Contact Information:			
Phone : _____ <input type="checkbox"/> Office <input type="checkbox"/> Cell		Alt. Phone: _____ <input type="checkbox"/> Office <input type="checkbox"/> Cell	
E-mail: _____			

Primary Care Physician (if different from Referring Provider)

Primary Care Provider Contact Information:			
Name: _____		Phone: _____	
<input type="checkbox"/> Office <input type="checkbox"/> Cell		Alt. Phone: _____	
		<input type="checkbox"/> Office <input type="checkbox"/> Cell	
E-mail: _____			
Department/Clinic: _____		Facility Name/Location: _____	

Patient Information

Last Name: _____		First Name: _____		Middle Initial: _____		Last four of SSN: _____	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth: _____		Age: _____		Rank: _____	
Name & Location of Command: _____		Branch of Service: <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marine <input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserve <input type="checkbox"/> IDWLRQDO *XDUG		MOS/AOC/Rate (Job Title): _____		Approx. Time In Service: _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Patient Contact Information:		Current Unit Commander:		Primary Case Manager Contact Information:	
Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Name: _____		Name: _____		Legal Status:	
Alt. Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Phone: _____ <input type="checkbox"/> Office <input type="checkbox"/> Cell		Phone: _____ <input type="checkbox"/> Office <input type="checkbox"/> Cell		<input type="checkbox"/> Disciplinary action pending	
E-Mail: _____		Alt. Phone: _____ <input type="checkbox"/> Office <input type="checkbox"/> Cell		Alt. Phone: _____ <input type="checkbox"/> Office <input type="checkbox"/> Cell		<input type="checkbox"/> Legal action pending	
		E-Mail: _____		E-Mail: _____		Litigation issues	
Approximate # of Deployments: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 – 3 <input type="checkbox"/> 4 or more		Military Status: <input type="checkbox"/> Motivated for continued service <input type="checkbox"/> Has at least 6 months of obligated service		Fitness for Duty Status: <input type="checkbox"/> Fit for Duty <input type="checkbox"/> Limited Duty or Profile <input type="checkbox"/> Medical Board		Potential for Active Duty Retention: <input type="checkbox"/> Very Likely <input type="checkbox"/> Unlikely <input type="checkbox"/> Likely <input type="checkbox"/> Very Unlikely	

Traumatic Brain Injury History

Traumatic Brain Injury: <input type="checkbox"/> Mild/Concussion <input type="checkbox"/> Moderate <input type="checkbox"/> Severe OIF/OEF Related: <input type="checkbox"/> Yes <input type="checkbox"/> No		Injury – Event: <input type="checkbox"/> Fall <input type="checkbox"/> Blast (e.g., IED, mortar, rocket, etc) <input type="checkbox"/> Crash <input type="checkbox"/> Other blow to the head <input type="checkbox"/> Other _____		Approximate Time of Injury: <input type="checkbox"/> < 3 months ago <input type="checkbox"/> 6 – 12 months ago <input type="checkbox"/> 3 – 6 months ago <input type="checkbox"/> > 12 month ago	
Any Loss of Consciousness: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, length of time of LOC _____		Any Post-traumatic Amnesia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Anterograde <input type="checkbox"/> Retrograde If yes, length of time _____		Hx of Multiple TBIs: <input type="checkbox"/> Yes <input type="checkbox"/> No Number _____	

Clinical Information (Provider only)

<p>Family/Support System:</p> <p> <input type="checkbox"/> Spouse <input type="checkbox"/> Friends <input type="checkbox"/> Significant Other <input type="checkbox"/> Supportive Command <input type="checkbox"/> Parents <input type="checkbox"/> Extended Family <input type="checkbox"/> Children <input type="checkbox"/> Other _____ </p>	<p>Social Stressors:</p> <p> <input type="checkbox"/> Work <input type="checkbox"/> Legal Issues <input type="checkbox"/> Marital <input type="checkbox"/> Disciplinary problems <input type="checkbox"/> Financial <input type="checkbox"/> Other _____ <input type="checkbox"/> Other Relational </p>
<p>Psychiatric Dx:</p> <p> <input type="checkbox"/> Depression <input type="checkbox"/> PTSD <input type="checkbox"/> Anxiety <input type="checkbox"/> Psychosis <input type="checkbox"/> Suicidality <input type="checkbox"/> Substance Abuse/Dependency <input type="checkbox"/> Other _____ </p>	<p>Comorbid Medical Conditions:</p>
<p>Current Symptoms:</p> <p> <input type="checkbox"/> Headaches <input type="checkbox"/> Blurry vision <input type="checkbox"/> Memory <input type="checkbox"/> problems Sleep Difficulties <input type="checkbox"/> Ringing in ears <input type="checkbox"/> _____ <input type="checkbox"/> Poor concentration Dizziness Balance <input type="checkbox"/> problems <input type="checkbox"/> Poor work functioning Irritability Sensitive </p>	<p>Current Medications (Names Only):</p>
<p>Clinical Issues:</p> <p> <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Disinhibited/inappropriate <input type="checkbox"/> Severe pain <input type="checkbox"/> Excessive alcohol use <input type="checkbox"/> Past suicidal/homicidal behavior <input type="checkbox"/> Domestic violence <input type="checkbox"/> Recent suicidal/homicidal thoughts <input type="checkbox"/> Impulsive <input type="checkbox"/> Prescription medication misuse <input type="checkbox"/> Assaultive/violent </p>	<p>Treatment History:</p> <p> <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Psychotropic medication <input type="checkbox"/> Sleep Evaluation <input type="checkbox"/> Acute Inpt Rehab <input type="checkbox"/> Drug/Alcohol Rehab <input type="checkbox"/> Medical Management <input type="checkbox"/> Cognitive Rehab <input type="checkbox"/> Inpt Psych hosp <input type="checkbox"/> Pain Management <input type="checkbox"/> Speech/Language Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> OT/PT <input type="checkbox"/> Other _____ </p>
<p>Involved in the Sole Provider Program: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, name of sole provider: _____</p>	<p>Treatment Compliance:</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p>

Descriptive Information

Reason for Referral/Anticipated Goal:

Additional Information/Comments:

Have you discussed the referral with patient? Yes No Is patient in agreement with referral? Yes No

Provider Signature: _____

Please fax referral to WCSRP at (254) 288-4763