National Intrepid Center of Excellence (NICoE)
Patient Referral Form

Referral Source

Referring Provider:

Date of Referral:

Department/Clinic:

Facility Name/Location:

Referring Provider Contact Information:

Phone : _____ ☐ Office ☐ Cell

Alt. Phone: _____ ☐ Office ☐ Cell

E-mail: _____

Primary Care Physician (if different from Referring Provider)

Primary Care Provider Contact Information:

Name:

Phone: ☐ Office ☐ Cell

Alt. Phone: ☐ Office ☐ Cell

E-mail:

Department/Clinic:

Facility Name/Location:

Patient Information

Last Name:

First Name:

Middle Initial:

Last four of SSN:

Gender: ☐ *Male* ☐ *Female*

Date of Birth:

Age:

Rank:

Name & Location of Command:

Branch of Service: ☐ Army ☐ Navy ☐ Air Force ☐ Marine ☐ Coast Guard ☐ Reserve ☐ National Guard

MOS/AOC/Rate (Job Title):

Approx. Time In Service:

Marital Status: ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Patient Contact Information:

Phone: _____ ☐ Home ☐ Cell ☐ Work

Alt. Phone: _____ ☐ Home ☐ Cell ☐ Work

E-Mail: _____

Current Unit Commander:

Name: _____

Phone: _____ ☐ Office ☐ Cell

Alt. Phone: _____ ☐ Office ☐ Cell

E-Mail: _____

Primary Case Manager Contact Information:

Name: _____

Phone: _____ ☐ Office ☐ Cell

Alt. Phone: _____ ☐ Office ☐ Cell

E-Mail: _____

Legal Status:

☐ *Disciplinary action pending*

☐ *Legal action pending*

☐ *Litigation issues*

Approximate # of Deployments: ☐ *0* ☐ *1* ☐ *2 – 3* ☐ *4 or more*

Military Status:

☐ *Motivated for continued service*

☐ *Has at least 6 months of obligated service*

Fitness for Duty Status:

☐ *Fit for Duty*

☐ *Limited Duty or Profile*

☐ *Medical Board*

Potential for Active Duty Retention:

☐ Very Likely ☐ Likely ☐ Unlikely ☐ Very Unlikely

Traumatic Brain Injury History

Traumatic Brain Injury:

☐ *Mild/Concussion*

☐ *Moderate*

☐ *Severe*

OIF/OEF Related: ☐ Yes ☐ No

Injury – Event:

☐ *Fall* ☐ *Blast (e.g., IED, mortar, rocket, etc)*

☐ *Crash* ☐ *Other blow to the head*

☐ *Other* _____

Approximate Time of Injury:

☐ *< 3 months ago* ☐ *6 – 12 months ago*

☐ *3 – 6 months ago* ☐ *> 12 month ago*

Any Loss of Consciousness:

☐ Yes ☐ No

If yes, length of time of LOC _____

Any Post-traumatic Amnesia:

☐ Yes ☐ No ☐ Anterograde ☐ Retrograde

If yes, length of time _____

Hx of Multiple TBIs:

☐ Yes ☐ No

Number _____

Clinical Information

Family/Support System:

- ☐ *Spouse*
- ☐ *Significant Other*
- ☐ *Parents*
- ☐ *Children*
- ☐ *Friends*
- ☐ *Supportive Command*
- ☐ *Extended Family*
- ☐ *Other* _____

Social Stressors:

- ☐ *Work*
- ☐ *Marital*
- ☐ *Financial*
- ☐ *Other Relational*
- ☐ *Legal Issues*
- ☐ *Disciplinary problems*
- ☐ *Other* _____

Psychiatric Dx:

- ☐ *Depression*
- ☐ *Anxiety*
- ☐ *Suicidality*
- ☐ *Other* _____
- ☐ *PTSD*
- ☐ *Psychosis*
- ☐ *Substance Abuse/Dependency*

Comorbid Medical Conditions:

Current Symptoms:

- ☐ *Headaches*
- ☐ *Sleep Difficulties*
- ☐ *Dizziness*
- ☐ *Irritability*
- ☐ *Blurry vision*
- ☐ *Ringing in ears*
- ☐ *Balance problems*
- ☐ *Sensitive to light/noise*
- ☐ *Memory problems*
- ☐ *Poor concentration*
- ☐ *Poor work functioning*
- ☐ *Emotional symptoms*

Current Medications (Names Only):

Clinical Issues:

- ☐ *Non-ambulatory*
- ☐ *Severe pain*
- ☐ *Past suicidal/homicidal behavior*
- ☐ *Recent suicidal/homicidal thoughts*
- ☐ *Prescription medication misuse*
- ☐ *Disinhibited/inappropriate*
- ☐ *Excessive alcohol use*
- ☐ *Domestic violence*
- ☐ *Impulsive*
- ☐ *Assaultive/violent*

Treatment History:

- ☐ *Individual Therapy*
- ☐ *Sleep Evaluation*
- ☐ *Drug/Alcohol Rehab*
- ☐ *Cognitive Rehab*
- ☐ *Pain Management*
- ☐ *Group Therapy*
- ☐ *Other* _____
- ☐ *Psychotropic medication*
- ☐ *Acute Inpt Rehab*
- ☐ *Medical Management*
- ☐ *Inpt Psych hosp*
- ☐ *Speech/Language Therapy*
- ☐ *OT/PT*

Involved in the Sole Provider Program: ☐ Yes ☐ No

If yes, name of sole provider: _____

Treatment Compliance:

☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

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 NICoE Continuity Services at (301) 319-3700