

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 "P "C "I "ctf			
MOS/AOC/Rate (Job Title): _____		Approx. Time In Service: _____		Marital Status: Single Married Separated Divorced Widowed			
Patient Contact Information:		Current Unit Commander:		Primary Case Manager Contact Information:		Legal Status:	
Phone: _____ Home Cell Work		Name: _____		Name: _____		Disciplinary action pending Legal action pending Litigation issues	
Alt. Phone: _____ Home Cell Work		Phone: _____ Office Cell		Phone: _____ Office Cell			
E-Mail: _____		Alt. Phone: _____ Office Cell		Alt. Phone: _____ Office Cell			
E-Mail: _____		E-Mail: _____		E-Mail: _____			
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 Unlikely Likely Very Unlikely	

Traumatic Brain Injury History

Traumatic Brain Injury: Mild/Concussion Moderate Severe		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	
OIF/OEF Related: Yes No		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

<p><u>Family/Support System:</u></p> <p>Spouse Friends Significant Other Supportive Command Parents Extended Family Children Other _____</p>	<p><u>Social Stressors:</u></p> <p>Work Legal Issues Marital Disciplinary problems Financial Other _____ Other Relational</p>
<p><u>Psychiatric Dx:</u></p> <p>Depression PTSD Anxiety Psychosis Suicidality Substance Abuse/Dependency Other _____</p>	<p><u>Comorbid Medical Conditions:</u></p>
<p><u>Current Symptoms:</u></p> <p>Headaches Blurry vision Memory problems Sleep Difficulties Ringing in ears Poor concentration Dizziness Balance problems Poor work functioning Irritability Sensitive to light/noise Emotional symptoms</p>	<p><u>Current Medications (Names Only):</u></p>
<p><u>Clinical Issues:</u></p> <p>Non-ambulatory Disinhibited/inappropriate Severe pain Excessive alcohol use Past suicidal/homicidal behavior Domestic violence Recent suicidal/homicidal thoughts Impulsive Prescription medication misuse Assaultive/violent</p>	<p><u>Treatment History:</u></p> <p>Individual Therapy Psychotropic medication Sleep Evaluation Acute Inpt Rehab Drug/Alcohol Rehab Medical Management Cognitive Rehab Inpt Psych hosp Pain Management Speech/Language Therapy Group Therapy OT/PT Other _____</p>
<p><u>Involved in the Sole Provider Program:</u> Yes No</p> <p>If yes, name of sole provider: _____</p>	<p><u>Treatment Compliance:</u></p> <p style="text-align: center;">Excellent Good Fair 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 NICOE Continuity Services at (301) 319-3700***