



REFERRAL TO OLD VINEYARD BEHAVIORAL HEALTH SERVICES

Phone: 336-794-4954

Fax: 336-794-4319

Contact Person _____ Phone Number _____

Patient Information:

Name of Patient _____ DOB _____ Gender _____

Address _____ State _____ Zip _____

Phone Number _____ SSN _____

Insurance Company _____ Policy # _____ DOB _____

Insurance Phone Number _____ Employer _____

Group Name _____ Group Number _____

Clinical Presentation: (Please check any that apply)

- Imminent danger to self, Imminent danger to others, Inability to care for self, Hallucinations, Psychotic depression, Catatonic, Self-mutilation, Acutely impaired reality, Need medication stabilization, Need medical detoxification, Impaired psychosocial function, Lack of acute behavioral control, Lack of progress in lower level care, Severe deterioration of functioning, Moderate deterioration of functioning, Mild deterioration of functioning, Inability to sleep, Depressed mood, Panic attacks, Obsessions/compulsions, Stress/anxiety causing distress, No support system, Can function in community

Any medical problems? _____

Medical hardware needed: _____

Current Medications: _____

Allergies _____

Date Old Vineyard Contacted: _____ Intake contact: _____

Old Vineyard Assessment scheduled for: _____ (Date and time)

Comments: _____

