REFERRAL TO OLD VINEYARD BEHAVIORAL HEALTH SERVICES

Phone: 336-794-3550
Fax: 336-252-2404

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:_____

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