Referral Form
The Military Program – Cedar Hills Hospital

*Please complete and send with attached clinical information to **mario.bolivar**@uhsinc.com or fax to (503) **535-7370***

Patient Name:_____ M-☐ F-☐ SSN:_____ DOB:_____ Pt Cell:_____

Active Duty Sponsor:_____ M-☐ F-☐ SSN:_____ DOB:_____ Cell:_____

Diagnosis (Primary / Secondary): _____

Medications: _____

Medical Concerns: _____

Pain Management Issues: _____

Substance Abuse: ☐-NA Date of Last Use: _____ Primary Substances: _____

_____

High Risk Alerts: ☐-Suicide ☐-Self Injury ☐-Aggression ☐-Fall ☐-Medical ☐-Sexual Aggression ☐-Sexual Victimization ☐-Elopement

Details: _____

Currently Hospitalized? ☐-NO ☐-YES; Contact Info:_____

Patient to Deploy? ☐-NO ☐-YES UCMJ Actions? ☐-NO ☐-YES Recommended Length of Stay: _____

Military Occupation: _____ Current Occupation: _____

Other Information: _____

Duty Station: _____

Unit Commander Rank/ Name: _____ Unit: _____

Non-DSN Phone: _____ Email: _____ Emergency #: _____

Will patient be discharged to the same Unit / Installation? ☐-YES ☐-NO; describe alternate plan: _____

_____

Fort/Base Behavioral Health or Substance Abuse Department: _____

Primary Clinical Contact: _____ Dept: _____

Non-DSN Phone: _____ Email: _____

Fort / Base Substance Abuse Program: _____ Dept: _____

Non-DSN Phone: _____ Email: _____

Service Substance Abuse Program Referrant: _____ Dept: _____

Non-DSN Phone: _____ Email: _____

PCM Contact: _____ Dept: _____

Non-DSN Phone: _____ Email: _____

Referring Professional: _____

Installation: _____ Dept: _____

Non-DSN Phone: _____ Email: _____ Emergency #: _____

A portion of the medical record will be provided at the time of discharge. If not initially included, a typewritten Discharge Summary will be faxed within three business days of the discharge. Please identify the individual to receive the Discharge Summary.

Name: _____ Phone: _____ Fax: _____