Referral Form
The Military Program -- Cedar Hills Hospital

*Please complete and send us this form, plus clinical information, via fax **503-535-7276** or email **mario.bolivar@uhsinc.com**. If you need to speak with us by phone, please call 503-535-7299*

THE MILITARY PROGRAM
CEDAR HILLS HOSPITAL

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 Substance: _____

_____

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 I 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:** _____