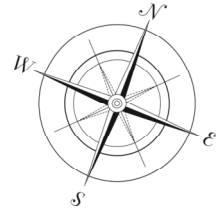


HOPEWELL
A Therapeutic Farm Community
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PSYCHIATRIST REFERRAL FORM

You may attach any forms you feel are necessary, but this form **must** be completed in its entirety

Date: ___/___/___ Physician's Name: _____

Address: _____

Applicant's Name: _____ Ph #: _____ Fax #: _____

D.O.B.: ___/___/___ SSN: ___/___/_____

DSM-IV DIAGNOSIS: Please [X] all that apply

AXIS I: [] Schizophrenia: [] Paranoid [] Undifferentiated [] Disorganized [] Residual [] Catatonic

[] Schizoaffective D/O: [] Bipolar Type [] Depressed type

[] Bipolar D/O: [] **Type I** [] Depressed [] Hypomanic [] Manic [] Mixed [] Unspecified
[] **Type II** [] Depressive episodes with hypomania [] Cyclothymic [] NOS

[] Major Depressive Disorder: [] Recurrent [] Single Episode

[] Anxiety D/O: [] Panic [] Generalized [] PTSD [] OCD [] Social

[] Other: _____

Additional Comments: _____

Axis II: [] Personality D/O:

[] Cluster A: [] Paranoid [] Schizoid [] Schizotypal

[] Cluster B: [] Antisocial [] Borderline [] Narcissistic [] Histrionic

[] Cluster C: [] Avoidant [] Dependent [] Obsessive-Compulsive

[] Other: [] NOS [] Traits: _____

[] MRDD: [] Mild [] Moderate [] Severe IQ: _____

Additional Comments: _____

Axis III: _____

Axis IV: Problems related to: [] Primary Support [] Social Environment [] Education
[] Occupational [] Economic [] Other _____

Axis V: Current GAF: _____ Highest in past year: _____

CURRENT MENTAL STATUS:

Orientation: _____ Affect: _____ Thought Content: _____

MOST RECENT HOSPITALIZATION: Location: _____ Date: _____

HOW MANY IN THE PAST YEAR: _____

PLEASE CHECK IF THE APPLICANT HAS ANY OF THE FOLLOWING:

SUICIDAL IDEATIONS HOMICIDAL IDEATIONS (**Current**)
 SUICIDAL IDEATIONS HOMICIDAL IDEATIONS (**Past Hx**) How long ago? _____

SELF-MUTILATING BEHAVIOR Method: _____ Date of last occurrence: _____

SEXUALLY INAPPROPRIATE BEHAVIOR (Please explain) _____

AGGRESSIVE OR ASSAULTING BEHAVIOR (Please explain) _____

NICOTINE DEPENDENCE Amount per day: _____ CAFFEINE DEPENDENCE Amount per day: _____

SUBSTANCE ABUSE/DEPENDENCE Date of last use: _____

Substance of choice: Alcohol Marijuana Cocaine Heroin Rx drugs Other _____

Please check all that apply: Does applicant have any problems with the following:

Incontinence Bathing Brushing Teeth Toileting Self Dressing Feeding Self Laundry

(If checked please describe limitations)

HOPEWELL IS A RURAL FARM COMMUNITY FOR ADULTS SUFFERING FROM MENTAL ILLNESS. DO YOU FEEL THE APPLICANT CAN FUNCTION INDEPENDENTLY WITHOUT CLOSE OBSERVATION IN AN OPEN & RURAL ENVIRONMENT? Yes No *** **(IF NO, PLEASE EXPLAIN)** ***

OUR COMMUNITY INCLUDES SEVERAL YOUNG CHILDREN. HAS THE APPLICANT HAD ANY DIFFICULTIES WITH CHILDREN? Yes No ** **(IF YES, PLEASE EXPLAIN)** **

TO YOUR KNOWLEDGE HAS THE APPLICANT BEEN ARRESTED OR CONVICTED OF A CRIME?
 Yes No *** **(IF YES PLEASE EXPLAIN & PROVIDE DATES)** ***

SUGGESTED LENGTH OF STAY: 3-6 MONTHS 6-12 MONTHS MORE THAN 12 MONTHS

HAS THERE EVER BEEN A HEAD INJURY: [] Yes [] No *** IF YES PLEASE EXPLAIN ***

HAS THERE EVER BEEN A HISTORY OF SEIZURES: [] Yes [] No

[] Petit mal [] Grand mal [] Pseudo [] Other _____ Date of last known: _____

PLEASE LIST ANY ALLERGIES: _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

CURRENT MEDICATIONS: *** MUST BE WRITTEN IN***

MEDICATION	DOSE	ROUTE	FREQUENCY	INDICATION
_____	/	/	/	/
_____	/	/	/	/
_____	/	/	/	/
_____	/	/	/	/
_____	/	/	/	/
_____	/	/	/	/

PRN MEDICATIONS: *** MUST BE WRITTEN IN ***

MEDICATION	DOSE	ROUTE	FREQUENCY	INDICATION
_____	/	/	/	/
_____	/	/	/	/
_____	/	/	/	/

PLEASE FAX THIS REFERRAL ALONG WITH THE MOST CURRENT PSYCHIATRIC EVALUATION & AT LEAST SIX MONTHS OF PROGRESS NOTES.

PHYSICIAN'S SIGNATURE: _____

ADDITIONAL COMMENTS: _____

