To refer please fill out, print and fax to 702-442-7190 or email to braintraincenter@aol.com

Stress Management
Clinical Psychotherapy
Mental Health Rehab Services
Referral Form

The Brain Train Center

Creative Stress Management Solutions for Adults and Children

Debra M. Doodkevitch LCSW #5682-C (Nevada),

Today's date:

☐ **NEW** ☐ **IN STATUS** ☐ **URGENT** ☐ **MANDATED** ☐ **INFORMATION ONLY**

CONTACT INFORMATION

Name of person initiating referral: (Your name)	Relationship: ☐ Family ☐ Discharge Planner ☐ Physician ☐ Group home ☐ Self ☐ Friend ☐ Caregiver/Guardian ☐ Assisted Living ☐ Agency
If community based, name of agency or facility	**How we may contact you: (Referring party information)** Referral phone#: FAX: Email:

CLIENT INFORMATION

Client name | Birthdate/Age | ☐ Medicare ☐ Medicaid ☐ United Healthcare ☐ Aetna ☐ Other:

Home address | Home phone: | Contact e-mail:

Client location at time of referral, if not presently at home address | Contact phone:

Is client aware of referral? ☐ Yes ☐ No	Can client legally make own healthcare decisions? ☐ Yes ☐ No	If no, has decision maker been consulted about referral for services? ☐ Yes ☐ No

REASON FOR SEEKING SERVICES

☐ Anger management	☐ Anxiety	☐ Poor coping skills	☐ Isolated, requests support
☐ Eating problems	☐ Fears, phobias	☐ Mental confusion (not Alzheimer's)	☐ Needs ongoing in home monitoring
☐ Sleep problems	☐ Adjustment to illness	☐ Depression	☐ Needs transition support
☐ Medication management	☐ Addictive behaviors	☐ Limited resources	☐ Limited mobility
☐ Inadequate housing	☐ Problems with ADLs	☐ Recent death/grieving	☐ Poor social skills
☐ Post Traumatic Stress	☐ Needs stress management training	☐ Age related memory impairment	☐ **At-risk behaviors Danger to self/ others, Wandering**
☐ Needs assistance accessing health care	☐ Hallucinations Auditory Visual	☐ Needs assist complying with medical regimen	☐ Victim of abuse

Other/ Comments:

SERVICES REQUESTED

☐ D/C Plan Assistance	Date of admission	Anticipated date of d/c:	
☐ Psychotherapy	☐ Med Eval/Management	☐ Ongoing case management	☐ Safety/Abuse Eval
☐ Clinical Diagnosis	☐ Basic Skills Training	☐ Crisis intervention	☐ Stress Management
☐ Psychosocial Rehab	☐ **NOT SURE**	☐ Information only at this time	**CASI (LOCUS) SCORE:**

☐ Other:

FOR OFFICE USE ONLY: **REFERRAL RCVD BY** _ **DATE RCVD** **REVIEWED** __________ **ON** INIT: _____

PRIOR AUTH NEEDED? ☐ YES ☐ NO **INSURANCE INFO: HPN AETNA MCR MCD CASH PAY OTHER :**

ELIGIBLE FOR SVCS? ☐ YES ☐ NO **SSN:** **DOB:** **MEMBER ID/POL#**

AUTH # : _ **DATES:** **D/C DATE:**

ACTION TAKEN:: ☐ APPT. MADE FOR COMPREHENSIVE ASSESSMENT FOR ☐ PSYCHOTHERAPY SERVICES ☐ RMH

☐ REFER FOR MEDICATION MANAGEMENT EVALUATION ☐ MEDICAL EVALUATION

☐ AT-RISK EVALUATION (MSE, HOME ASSESS, CRISIS INTERVENTION)

☐ APPT MADE NEUROFEEDBACK/BIOFEEDBACK ONLY ☐ MSGS LEFT, NO ANSWER ☐ LETTER SENT, NO REPLY ☐ NO SHOW

FINAL DISPOSITION:

☐ APPT MADE, KEPT, CONSENTS DATE/TIME APPT SET: _____ RESCHEDS: ___________________________

☐ OFFERED SERVICES BUT DECLINED REASON STATED: ____