Hampstead Hospital Adult Referral Questionnaire

Name: _____ **DOB**: _____ **Date**: _____

Current Residence: _____

Patient's Gender: _____ Female _____ Male _____ Transgender

Patient's program of interest: _____ In-patient _____ Partial Hospitalization

Patient's Current Height:			**Patient's Current Weight:**
Reason for Referral/Description of Behaviors/Problem:			
	No	**Yes**	**If Yes please describe/explain**
Psychiatric issues and diagnosis			
Substance Use			Substance Amount Last Use
Recent overdose			
History of detoxes, placements or hospitalizations			
Are you currently experiencing detox symptoms?			
Current medications			
Medical conditions			
Seizure history/newly diagnosed hepatitis/esophageal varices or GI bleed/insulin dependence/insulin pump/assistive devices like cane, crutch, wheelchair/C-PAP			
Legal Involvement (Past, current, or pending)			
Self-injurious behaviors (cutting, burning, hitting…)			
Assistance with ADL's (Activities of Daily Living)			

Employment; where, what type of work			
Living situation			
Additional Information:			

_____ _____

Person completing form Date/Time Patient Date/Time

Please fax completed questionnaire to (603) 329-9374