

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			<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; text-align: center;">Substance</td> <td style="width: 33%; text-align: center;">Amount</td> <td style="width: 34%; text-align: center;">Last Use</td> </tr> </table>	Substance	Amount	Last 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