CHRIS KYLE PATRIOTS ★ HOSPITAL

Referral Form

Please complete and fax with attached clinical information
To 907-433-7330

Patient Name: _____ **M-☐ F-☐ SSN:** _____ **DOB:** _____ **Pt Cell:** _____
Active Duty Sponsor: _____ **M-☐ F-☐ SSN:** _____ **DOB:** _____ **Pt Cell:** _____
Diagnosis (Primary/Secondary): _____
Medication: _____
Medical Concerns: _____
Pain Management Issues: _____
Substance Abuse: ☐-NA Date of Last Use: _____ Primary Substances: _____
_____
High Risk Alerts: ☐-Suicide ☐-Self-Injury ☐-Aggression ☐-Fall ☐-Medical ☐-Sexual Aggression ☐-Sexual Victimization ☐-Elopement
Details: _____
Currently Hospitalized? ☐-No ☐-Yes; Contact Information: _____
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/Base Substance Abuse Program: _____ **Dept:** _____
Non-DSN Phone: _____ **Email:** _____
Service Substance Abuse Program Referent: _____ **Dept:** _____
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:** _____