Turning Leaf
Residential Rehabilitation
621 E. Jolly Road
Lansing, MI 48910
517-393-5203 Phone
517-393-8968 Fax

PHYSICIAN REFERRAL APPLICATION

Please print or type

Applicant's Name: ____

Social Security Number: ____

Address: ____

City/State/ZIP ____

Phone: (   ) ____

Male ☐ Female ☐ Marital Status: ________________ Birthdate: _____/_____/_____

ALLERGIES & REACTIONS:

Diagnosis (DSM-IV-R)

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Prognosis:

PSYCHIATRIC HISTORY:

Please attach *copies* of recent records, reports, discharge summaries.

A. Current Mental Status

B. Psycho-social-work history (hospitalizations, education, employment)

C. **Applicant's most recent living situation**

D. **Is the applicant aware of the scope and purpose of Turning Leaf Residential Rehabilitation and motivated to participate?**

E. **What are your anticipated goals and outcomes for the applicant at Turning Leaf Residential Rehabilitation?**

F. **How long do you anticipate the length of stay?**

G. **Is the client able to meet own basic needs?** _ Yes _ No

Please describe any limitations.

Staff interventions needed?

H. **History and/or current likelihood of:**

Suicidal behavior	_ Yes	_ No
Violent/assaultive behavior	_ Yes	_ No
Abusing drugs or alcohol	_ Yes	_ No
1. Legal, family, medical problems as a result of substance abuse	_ Yes	_ No
2. Has substance use complicated psychiatric treatment	_ Yes	_ No
Self-abusive behavior	_ Yes	_ No

If yes to any of the above, please explain.

I. **Past psychiatric treatment (including medications) and response.**

MEDICAL HISTORY:
Please attach copies of recent records/reports.

_____ A. Medical & physical illness history: (any allergies or surgeries)

_____ B. Current physical illnesses

_____ C. Any physical limitations/restrictions _ Yes _ No
Describe.

CURRENT MEDICATIONS:

Medication	Dose	Route	Schedule	How Long?

Any PRN medications and for what target symptoms:

Medication	Dose	Route	Frequency?	Purpose?

Do you feel the medications are adequate or do you recommend a change in the current regime?

PLEASE SEND A ONE-MONTH SUPPLY OF ALL MEDICATIONS WHEN APPLICANT BEGINS RESIDENCY.

Physician Name: ______________________________

Address: ______________________________

City/State/ZIP ______________________________

Phone ______________________________

Signature ____________________ **Date** ____________

Other supporting professionals: ______________________________**Name**

Phone ______________________________

Name______________________________

Phone ______________________________

ADDITIONAL NOTES AND COMMENTS:

Applicant must be at least 18 years old. Turning Leaf Residential Rehabilitation does not discriminate on the basis of religion, race, color, national origin, gender, or marital status.