



GOULD FARM

Since 1913 · We Harvest Hope

www.gouldfarm.org

100 Gould Road, P.O. Box 157
Monterey, MA 01245-0157
Phone: 413-528-1804 Fax: 413-645-

1022

Physician's Referral Form

Name of applicant _____ Date _____

Address _____ City _____

State _____ Zip _____ Home phone number _____

Marital status _____ SS# _____ Date of birth _____

Insurance that would cover hospitalization for medical reasons:

Carrier _____ Policy # _____

Current Medication Schedule

Medication

Dosage

Frequency

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Emergency P.R.N. Medication (**must** be indicated)_____

How long has applicant been on present medication?_____

Medical Profile

(responses to be typed on a separate sheet)

- A. General medical history
- B. History of any alcoholism and/or drug addiction
- C. Physical activities applicant should avoid
- D. Allergic or other reactions to psychotropic, antibiotic or other drugs

Psychiatric Profile

(responses to be typed on a separate sheet)

- A. Diagnosis_____Prognosis_____
- B. Submit a detailed, current psychiatric evaluation of the patient, including your personal judgment as to whether the applicant is suicidal, homicidal, or in any way inclined to be destructive toward him/herself or others.
- C. Submit a detailed psychiatric history. Have the patient sign and send authorization to all agencies from whom care has been received so summaries can be sent directly to us.
- D. Please state clearly the applicant's present place of residence and life situation; whether employed or in school or how otherwise using his/her time; the highest level of education attained; why his/her present living situation is not satisfactory or not adequate.
- E. List primary goals the applicant wishes to achieve.
- F. Is the applicant able to be responsible for his/her own behavior and safety in an open rural environment; able to fully care for his/her personal hygiene needs and laundry without staff prodding; fully able and motivated to meet all program requirements; able to refrain from use of alcohol and illicit drugs altogether; able to confine smoking to designated areas; able to function relatively independently without close surveillance? Yes___No___. If the answer to any of these questions is no, please explain in detail on a separate sheet.
- G. Suggested length of stay ___less than 6 months___6-12 months___more than 12 months

To Be Signed by Referring Physician Only

Physician_____Date_____

Address_____City_____State_____Zip_____

Phone_____

Signature of Physician_____

Social Worker/Referral
Contact_____Phone_____

Parent or
Guardian_____

Address_____City_____State_____Zip_____

Phone

To Be Signed by Applicant

**I understand the requirements and expectations of the Gould Farm program in detail and
desire to enter the program.**

Signature_____Date_____