

The California Transition Center for Care of Combat Veterans: The Pathway Home

Referring Provider Application

Dear Provider,

The Pathway Home is a residential rehabilitation program for combat stress/PTSD and does not offer full medical services. Therefore, we *cannot* accept medically unstable individuals. We rely on the individual's ability to be independent with regard to ADLs. All medical and psychological conditions will be fully- assessed on a case-by-case basis to determine eligibility.

The Pathway Home is open to exploring special circumstances and will look at each case individually. We would be glad to discuss any questions and/or concerns you may have. You may contact the admissions coordinator by telephone (707) 948-3031 or email: Kathy.Loughry@thepathwayhome.org. In order to expedite this application, we have provided a checklist of documentation that may need to be attached if applicable. Should we have any questions regarding information received, we will contact the treatment provider.

We understand that this is a lengthy application and want to make sure that we are the right treatment provider for each warrior. We appreciate your time and effort in completing this application.

Thank you,
The Pathway Home Staff

DOCUMENT CHECKLIST FOR APPLICATION

- Legible faxed copy of DD-214 (Member #4 copy, Must be Honorable)
- Outpatient summary of treatment for psychological conditions over last year
- Psychiatric and Medical hospital discharge records for past year
- Summary of pertinent records for current ongoing medical conditions (for example most recent CBC for individuals with Anemia, FBS & HgbA1c for diabetes, cardio tests for heart disease)
- Proof of Negative (PPD) Tuberculosis Skin Test and/or Chest X-Ray
- Provide a brief summary of any legal issues (e.g. probation, parole, and pending legal charges). Please include points of contact.
- Psychological and/or Neuropsychological Testing Report, include any TBI evaluation and treatment recommendations
- List of all (medical and psychiatric) current medications.

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WARRIOR'S PERSONAL INFORMATION

Warrior's Name: _____

Address: _____ Physical Mailing

Home Phone: _____ Cell: _____

Place of Birth: _____ DOB: _____

SSN: _____ Gender: Male Female

Email _____

Legal Charges Pending: No Yes

Living Arrangements: Alone With Family With Friends Roommate Homeless
 With spouse/partner Currently Active Duty

Please check answers that apply:

<u>Ethnicity</u>	<u>Marital Status</u>
<input type="checkbox"/> African American	<input type="checkbox"/> Never Married
<input type="checkbox"/> Asian/ Pacific Islander	<input type="checkbox"/> Married
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Domestic Partner
<input type="checkbox"/> Hispanic / Latino American	<input type="checkbox"/> Separated - Legal <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Native American	<input type="checkbox"/> Divorced - If yes, how long? _____ How many times? _____
<input type="checkbox"/> Other (please list)	<input type="checkbox"/> Widowed - If yes, how long? _____
<input type="checkbox"/> Do you have children? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes answer below)	<input type="checkbox"/> Common Law

Children's Names	Age	Do you have physical and/or legal custody?
_____	_____	<input type="checkbox"/> Phys. <input type="checkbox"/> Legal <input type="checkbox"/> % <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Phys. <input type="checkbox"/> Legal <input type="checkbox"/> % <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Phys. <input type="checkbox"/> Legal <input type="checkbox"/> % <input type="checkbox"/> No

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PERSONAL HISTORY

Pre-Military

History of Mental Illness in family? NO YES

Professional counseling prior to military? NO YES

History of disruptive or antisocial behavior? NO YES

Victim of childhood physical abuse? NO YES

Victim of childhood sexual abuse NO YES

Victim of sexual assault? NO YES

Military

History of violent acting out or antisocial behavior? NO YES

Victim of sexual assault? NO YES

Victim of domestic violence? NO YES

MILITARY INFORMATION

Military Status: Active Reserve National Guard Veteran

Military Installation (if Active Duty): _____

Reserve/National Guard Assigned Station or Armory: _____

Duty Address: _____

Phone: _____ Fax: _____

Service Entry Date: _____ Discharge Date: _____

War Zone Date(s): _____

Military Jobs (title): _____

Highest Rank: _____

Service Connected: No Yes Application Date (if pending): _____

Percentage: _____ Total Income: _____

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PSYCHIATRIC PROVIDERS

Please list the name, agency, address and phone number for all current psychiatric providers:

Name	Agency	Address	Phone	Date of last visit
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Please describe all medical and psychiatric issues including military stressors, diagnoses, and related symptoms. Please include a description of current treatments, interventions, the warrior's response and your recommendations and goals for the warrior in residential treatment.

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PROBLEM CHECKLIST

Please check symptoms the warrior has experienced within the last 6 months

- | | | |
|--|---|--|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Denial or shock | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Despair | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Feeling Jumpy |
| <input type="checkbox"/> Work or School Problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Frustration |
| <input type="checkbox"/> Excess Smoking | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Avoiding people |
| <input type="checkbox"/> Emotional Withdrawal | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Alcohol/Drug Use |
| <input type="checkbox"/> Easily Startled | <input type="checkbox"/> Intrusive Thoughts | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Feelings of Loss | <input type="checkbox"/> Feeling Detached |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Being On Guard | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Avoiding Places |
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Difficulty Eating | <input type="checkbox"/> Avoiding Intimacy |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic Attacks |

PSYCHIATRIC TREATMENT HISTORY No Yes*

*If yes, please answer following question, if no, continue to next session

In the past year how many sessions of outpatient mental health treatment has the warrior received?

- None 1-6 7-12 13-26 26-52 53+

Dates: _____ to _____

Reason: _____

In the past year how many days of inpatient psychiatric hospitalization has the warrior received?

- None 1-6 7-12 13-26 26-52 53+

Dates: _____ to _____

Reason: _____

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In the past year how many days of residential mental health rehabilitation care has the warrior received?

- None 1-6 7-12 13-26 26-52 53+

Dates: _____ to _____

Reason: _____

**CURRENT PSYCHIATRIC
MEDICATION:**

DOSAGE:

REASON:

<u>CURRENT PSYCHIATRIC MEDICATION:</u>	<u>DOSAGE:</u>	<u>REASON:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the warrior had psychological or neuropsychological testing within the past two years?
(If yes please send a copy of the completed report)

NO

YES

HIGH RISK BEHAVIOR

Does the warrior have a history of any of the below within the past 60 days?

Suicidal Ideation

Homicidal Ideation

Suicidal Urges

Homicidal Urges

Suicidal Behavior (s)

Homicidal Behavior (s)

Suicide Plan (s)

Homicidal Plan (s)

Suicidal Attempt (s)

Homicidal Attempt (s)

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If yes to either question above, please provide dates and a description:

Has the warrior been psychiatrically or medically hospitalized due to any of the above behaviors within the past 1 year? (If hospitalized in the past 1 year, please attach hospital discharge summaries)

If yes, Psych Inpt. Hosp Voluntary Involuntary Other _____

If yes, please provide dates and a description:

Has the warrior engaged in any other high risk behavior? NO YES

If yes, please provide dates and a description:

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SUBSTANCE USE HISTORY No Yes

If yes, Please identify: length of use (daily, weekends only, 3 day, binge, etc)
 number of uses per week & date of last use.

1. No Alcohol → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____

2. No Barbiturates → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____

3. No Cannabis → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____

4. No Club Drugs (ecstasy) → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____

5. No Cocaine → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____
How used? _____

6. No Hallucinogens → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____

7. No Meth/Amphetamines → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____
How used? _____

8. No Opiates (Heroin) → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____
How used? _____

9. No PCP → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ and date of last use _____

10. No Other: Name _____
 0-6 x wk 7-10 x wk 12+ week
Length _____ date of last use _____

11. No Prescription Abuse → Yes 0-6 x wk 7-10 x wk 12+ week
Length _____ date of last use _____

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MEDICAL INFORMATION

MEDICAL HEALTH CARE PROVIDERS

Please list the name, agency, address and phone number for all current medical providers:

Name	Agency	Phone	Last Date of Service
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MEDICAL PROBLEMS CHECKLIST

Please check all conditions the warrior has experienced within the past 6 months

<input type="checkbox"/> Allergies (Medicine, Environmental and Dietary)	<input type="checkbox"/> Hepatitis (indicate A, B, C, E, or other below)
<input type="checkbox"/> Anemia (please attach CBC results for the past month)	<input type="checkbox"/> Hypertension (Indicate treatment and B/P below)
<input type="checkbox"/> Breathing difficulties, asbestos exposure, COPD, Asthma	<input type="checkbox"/> Impulse to harm self or others
<input type="checkbox"/> Blood in stool, urine, phlegm, vomit	<input type="checkbox"/> Memory Problems (indicate Mild, Moderate or Severe below)
<input type="checkbox"/> Cancer (Indicate site and treatment below)	<input type="checkbox"/> Nicotine Addiction
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Pain, Numbness, Weakness in Joint or Limb
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Positive Skin Test for TB (Indicate Prophylactic Treatment below, Send Chest X Ray completed within last 6 mo)
<input type="checkbox"/> Colitis	<input type="checkbox"/> Seizures (list type below)
<input type="checkbox"/> Diabetes (Indicate treatment, FBS & HgbA1c results below)	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Head injury with loss of consciousness	<input type="checkbox"/> Stomach Pain
<input type="checkbox"/> Heart Disease (Indicate specific diagnosis and Cardio tests below)	<input type="checkbox"/> Stomach Ulcers, Active bleeding

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Please describe symptoms, medications and treatments from items selected above:

Does the applicant have TBI (Traumatic Brain Injury)? No Mild Moderate Severe

Please describe symptoms, medications and treatments:

Does the applicant require any special medical equipment? No Yes

If yes, what equipment? Who will supply it? Reason?

Date of last complete physical (please send copy if within past year): _____

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FAMILY AND RELATIONSHIP STATUS

Are the applicant and his family interested in participating in counseling [Check all that apply]

- No Yes, if yes, please continue and identify who is interested Warrior
 Spouse w/w/o Children Significant Other / Relative _____

What type of counseling are they interested in? [Check all that apply]

- Family Counseling Couples Counseling Video/Telephone Conferencing
 Family Workshops Visiting Warrior Other _____

Can family meet financial obligations while warrior is in treatment? No Yes

If no – please briefly describe below

ADMISSION AND DISCHARGE PLANS

Does the warrior have transportation to The Pathway Home?

- No.** If no, assistance is available upon request via a Veterans Air Transport Program
 Yes. If yes, please explain how the applicant will be transported to the program

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Does the warrior have plans for returning to the referring provider after treatment at The Pathway Home? No Yes

If no, please explain

REFERRING PROVIDER'S INFORMATION

Referring Provider: _____ Phone: _____
Email address: _____ FAX: _____
Agency/Organization: _____ Date: _____
Referring Clinician's Signature: _____
Title: _____

*Thank you for your time in filling out the application to refer the Warrior for treatment at The Pathway Home. **Please Fax all applications and any supporting documentation to the confidential fax at the Pathway Admissions Office 707-948-3029***

We have a 48-hour (business hour) turn around on applications. Once the Admission Team has accepted the Warrior you will be notified what the next steps are.

If unable to reach the Pathway Admissions Office, you may contact executive director Fred Gusman at (707) 287-2969 or our 24-hour nursing station at (707) 948-3031.

We look forward to receiving this application and talking with you soon.