

CENTRAL TEXAS VETERANS HEALTH CARE SYSTEM, WACO INTEGRATED CLINICAL FACILITY
POST TRAUMATIC STRESS RESIDENTIAL REHABILITATION PROGRAM

REFERRAL QUESTIONNAIRE

The following information is required when referring veterans to the Post Traumatic Stress Residential Rehabilitation Program at the Waco CTVHCS. **(Complete front and back.)**

Please Note:
This referral information must be completed by a Mental Health Provider, such as a Physician, Psychiatrist, Psychologist, Social Worker, or Vet Center Counselor.

1. **Veteran's Identifying Data:** Date: _____
Name: _____ Age: _____ SSN: _____
Address: _____ Tel.# (____) _____
City: _____ ST _____ ZIP _____
Branch of Service: _____ Dates of Active Duty: _____
Service Connected? Yes _____ No _____ Percent _____% Condition: _____

Months in war zone: _____ Wounded? _____
2. Is the Veteran's application complete? Yes _____ No _____
3. How long has this Veteran been in treatment with you? _____
4. Does s/he have special needs? _____
5. List medications the Veteran is taking: _____
6. _____
7. List any diagnoses in addition o PTSD: _____
8. _____
9. Please verify that the Veteran meets admission criteria:
- a. Served in combat. _____ Yes
 - b. Has significant symptoms of PTSD from combat. _____ Yes
 - c. Is not psychotic; not a suicide or homicide risk. _____ Yes
 - d. Has no pending legal problems. _____ Yes
 - e. Is alcohol/drug free for three (3) months, or has recently completed a substance abuse program. _____ Yes
 - f. Is not taking medication prohibited in the program. _____ Yes

- g. Has no medical or cognitive problems which might preclude participation in treatment. _____ Yes
- h. Has shown willingness/ability to engage in intensive group treatment. _____ Yes
- i. Is receptive to feedback and willing to make changes in self. _____ Yes

10. Referring Source Data: (please print)

- a. Referring Person: _____
- b. Agency or program: _____
- Address: _____ Tel.# (____) _____
- City: _____ ST _____ ZIP _____

Please note: If Veteran is currently hospitalized in a VA hospital, send a copy of social history/assessment along with this referral.

Mail to: CTVHCS (116/PRRP)
 4800 Memorial Drive
 Waco, TX 76711