



Please send completed form to:  
 Marlena Warren, Director of Admissions  
 CooperRiis, 101 Healing Farm Lane  
 Mill Spring, NC 28756  
 828-894-5557  
 828-894-7111 FAX  
 Please call or email [Marlena.Warren@CooperRiis.org](mailto:Marlena.Warren@CooperRiis.org)  
 with any questions. Additional forms at [www.CooperRiis.org](http://www.CooperRiis.org)

**Referral for Residency from the Applicant's Treatment Team**

Applicant's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male  Female  Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Applicant's Parent(s), Guardian(s), or Spouse: *(Please circle one)* \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

**If the applicant has a preference between CooperRiis' two campuses, please indicate that below.**

Rural – Mill Spring     Urban - Asheville    Is the applicant open to either campus?    Yes     No

**I. Strategic questions.** Your considered and focused opinion about these issues is very important to us; please **ATTACH** your brief answers: *(Any member of the Team may address these.)*

- 1) What/Who prompts you to refer this applicant?
- 2) What do you perceive to be the key goals, hopes and dreams of the applicant?
- 3) What are the applicant's fundamental strengths that we can build on?
- 4) What are the crucial issues impeding the applicant's progress?
- 5) What are the main resources that CooperRiis can provide to assist with the applicant's recovery?

**II. Psychiatric Profile.** Please attach all relevant records, psycho-social summaries and discharge summaries. Please also have the applicant sign and send authorization forms to relevant agencies/hospitals, asking that they send care summaries to us. *(The applicant's physician must fill out this section.)*

**A.** Applicant's Diagnosis (DSM-IV-R) \_\_\_\_\_ Axis III: \_\_\_\_\_

Axis I: \_\_\_\_\_ Axis IV: \_\_\_\_\_

Axis II: \_\_\_\_\_ Axis V: \_\_\_\_\_

**B.** Please submit a detailed, current psychiatric evaluation and prognosis, along with an overview of the applicant's psychiatric, social, educational and work history.

**C.** What is your assessment about whether or not the applicant is currently at risk of suicide or inclined in any way to be destructive or abusive toward him or herself or others? Be specific as well about the history of such behavior.

**D.** Is the applicant able to be responsible for his/her own behavior and safety in an open rural and/or urban environment, able to care for his/her personal hygiene, able and motivated to participate in the CooperRiis program, able to refrain completely from the use of alcohol and illegal drugs, able to confine cigarette smoking to designated areas, able to function relatively independently without close supervision?

Yes     No    *If the answer is no, please fully explain why in an attachment.*

**III. Current Medications:** The applicant must arrive with at least a two week supply of all current medications. The medications will be dispensed based on this form. If there are ANY changes before the exploratory visit, please update us with a current medications list at the time of the visit.

Medication	Dose	Time Taken	Reason Prescribed

Any PRN medications and for what target symptoms:

Medication	Dose	Time Taken	Reason Prescribed

Previously unsuccessful medications? \_\_\_\_\_

Is the applicant treatment adherent? If no, explain \_\_\_\_\_

**IV. Complementary Care for the Resident.** CooperRiis’ program is comprehensive. In addition to providing psychiatric services, psycho-education, work-training, and a therapeutic milieu, we incorporate nutritional and dietary planning, access to massage therapy and other modalities, smoking cessation and physical exercise programming into the resident’s personal recovery plan. Which of these complementary approaches would be most beneficial for the applicant? (Please attach your answer.)

V. Your suggested length of stay for the applicant? \_\_\_\_\_

**VI. Physician Signature:** \_\_\_\_\_ (Attests to Section II and III)

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Treatment Team Contact Person: \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

**PLEASE SEND AT LEAST A TWO WEEK’S SUPPLY OF ALL CURRENT MEDICATIONS**

07/10