

McLean OnTrack™ Patient Referral Form

Please download this form before filling it out. Please type or print clearly.
Please fax to **617.855.3820**, Attn: Allison Nelson-Eliot, LICSW

Date: _____

Name: _____ Phone: _____ Email: _____

Address: _____

Age: _____ DOB: _____ Sex: _____ Occupation: _____

Why do you want to join this program?

Please describe the problems or experiences for which you would like help. Please be specific.

When did you first notice these problems?

Have doctors, therapists, or counselors told you that you may have bipolar disorder, schizophrenia, schizoaffective disorder, or other illness?

When was the first time you ever received treatment for mental health issues of any kind (e.g., seeing a therapist, counselor, or psychiatrist)?

What kind of treatment have you received since the start of the experiences you describe above?

Have you been psychiatrically hospitalized? If so, when, where, for what reason, and how long?

Do you use any substances (e.g., alcohol, marijuana, hallucinogens, stimulants, etc.)?

Have you ever experienced thoughts of suicide or attempted suicide?

Have others ever been concerned about violent or aggressive behavior in you? Have you ever been arrested, charged, or convicted of anything?

Have you experienced any traumatic events in your life (e.g., physical, sexual, emotional abuse)?

Are there any current medications? Do you take them? Any side effects or problems with the medications?

Do you have any medical problems?

Do you live alone, with family, or other? Please describe.

How involved are family or friends? Do you have other supports in the community?

Please return the completed form by fax or postal mail to:
McLean Hospital
McLean OnTrack, Attn: Allison Nelson-Eliot, LICSW
115 Mill Street, Mail Stop 343
Belmont, MA 02478
Fax: 617.855.3820

Questions? Please email mcleanontrack@partners.org.

For staff use only:
Appropriate for the OnTrack Program? Yes No
Plan: