McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Support, Treatment, and Resilience (STAR) Program Referral Form

Please download this form before filling it out. Please type or print clearly.
Fax completed form to **617.855.3820**, Attn: Sarah Burke, LICSW

Date: _____

Patient Name: _____ Patient's contact info: _____

Address: _____

Age: _____ DOB: _____ Sex: _____

Are you a referring clinician? ☐ Yes ☐ No

If yes, please indicate clinic/affiliation: _____

Phone: _____ Fax: _____ Email: _____

What is the reason for this referral?

Please describe patient's symptoms. Please be specific.

Has the patient been given psychiatric diagnoses? If so, please list.

What kind of care has the patient received since the onset of illness?

Has the patient been psychiatrically hospitalized? If so, when, where, for what reason, and how long?

Is there any history of or current substance abuse (e.g., alcohol, marijuana, hallucinogens, stimulants, etc.)?

Has the patient ever experienced suicidal ideation or attempted suicide?

Has the patient ever been violent or aggressive?

Does the patient have any history of trauma? (e.g., physical, sexual, emotional abuse?)

What are the patient's current medications?

Does the patient live alone, with family, or other? Please describe and provide contact information.

Please return the completed form by fax or postal mail to:
McLean Hospital
STAR Program, Attn: Sarah Burke, LICSW, Clinic Director
115 Mill Street
Belmont, MA 02478-1064
Fax: 617.855.3820

With any questions, email **sgburke@partners.org**.

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