

DWIGHT D. EISENHOWER ARMY MEDICAL CENTER (DDEAMC)
Residential Treatment Facility (RTF) Referral Intake Information

For Agency Use Only

RTF Admit: Y/N

Group #: _____ Cycle Date: _____ Patient Arrival Date: _____

Counselor Notified: Y/N Date & Time: _____ Mode of Travel: _____

Escort Name & Rank: _____ Cell #: _____

Expected Date of Arrival: _____ Expected Time of Arrival _____

Referring Provider Information

Name & Title of Person Making Referral: _____

Case Manager Name and Phone Number: _____

Address: _____

Office Number: _____

Fax Number: _____

Patient's SUDCC Counselor: _____

Installation: _____

Command Information *Please inform us if any pending command name change

CDR's Name: _____

CDR's Office Number: _____

CDR's Email Address: _____

Cell Number: _____

First Sergeant's Name: _____

1SG Office Number: _____

1SG's Email Address: _____

Cell #: _____

If applicable:

Civilian Supervisor's Name/ Rank/Title: _____

Office Number: _____

Supervisor Email Address: _____

Patient Information

Name: Last, First, MI _____ DOD ID# _____ Gender _____ Marital Status _____

Rank _____ AGE _____ DOB _____ Race _____ MOS _____ TIS _____ ETS _____ Branch of Service _____

DSM-5 Diagnosis(es) _____

Was the patient Command-Referred or Self-Referred? _____

Does patient meet ASAM criteria for RTF treatment? If so, explain why? _____

The Eisenhower RTF is designed to treat and rehabilitate Service Members who will be retained in their careers. Is patient appropriate for retention for Active Duty? Yes No

*Please ensure SM is placed on profile/restricted duty through requested dates of treatment per MEDCOM Policy 21-019 BH eprofiling Standardization Policy.

Does Command support retention of this Service Member? Yes No

Does patient have pending legal action? _____

Is patient pending an administrative separation? If so, what type? _____

What is the level of support for patient by Command, Family, Other? _____

Please rate patient's motivation for treatment, on a scale of 1-10 (Ten being the highest): _____

Medical

Primary Care Provider: _____

Phone Number: _____

Patient's profiles, medical concerns, if any, to include COVID19 concerns (if none, indicate): _____

Current Medication List (Rx and OTC): _____

SUDCC History

What criteria does the patient meet for moderate or severe substance use?

Previous alcohol/drug or Behavior Health treatment/counselor, diagnosis (Dates, location, completed, failed): _____

List history and dates of legal charges for DUIs, Under Age Drinking, Public Intoxication, Possession of Substance, Previous Civilian Arrests, etc.: _____

Date of last Substance/ETOH Use: _____

Duration of Last Use: _____

Specify type and amount used (if more than one used, please specify): _____

Is there any additional information that we should be aware of, not addressed in the questions above? If so, please explain:

IMPORTANT: Include this document with the Commander's Memorandum for Treatment when submitting your referral. Please send your referral via encrypted email to usarmy.gordon.medcom-eamc.list.rtf-referral@health.mil. Should you have any questions or need any additional information, please reach out to Ms. Ana Vlasic at 706-787-8672 or email: ana.m.vlasic.civ@health.mil.