

BURNING TREE MEDICAL CERTIFICATION FORM

Fax to Admissions at (972)962-7376

Attention, Doctors: Burning Tree is not licensed as a hospital or detox facility; we are licensed as a residential facility only. Further, we are located outside of town, over 30 minutes away from a hospital. Therefore, please rule out the need detox or acute medical care. Should you have questions or concerns, please call Admissions at (877) 962-7374. Thank you for your diligence.

Patient Name: _____ Gender: M F Age: ____ DOB: _____

Has this person been a patient of yours before today? ____ Yes/No If so, how long? _____

Alcohol and/or Drug History:

Substance: _____, Frequency: _____, Last Use: _____

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Psychiatric Treatment History (total # episodes = ____):

Prior psychiatric treatment(s): where/ adm. date/ type of tx/ # days/type of discharge

1) _____

2) _____

Previous CD/MH diagnoses: _____ Psychotic? _____

Is patient suicidal? ____ History of suicide attempts/Dates? _____

Current Emotional State: _____ Self Mutilating Y/N _____

Eating Disorder Y/N If so, previously treated? Y/N Date treated: _____

General Health History:

List any significant medical problems (past & present) _____

_____ At risk for TB, HIV, STD? ____

Hepatitis? Y/N, Type: A, B, C; When Diagnosed: _____, tx: _____

Ever had seizures? Y/N - Dates: _____ Back Problems: Y/N - _____

DT's? Y/N - Dates: _____ Gastrointestinal? Y/N - _____

Diabetes? Y/N - Date Diagnosed: _____ Genitourinary? Y/N - _____

Cardiopulmonary? Y/N - _____ Neuropsychiatric? Y/N - _____

Blood Pressure: _____ Migraines? Y/N - _____

Drug/Natural Allergies: _____ Tobacco? Y/N: Smoke/Dip/Chew - _____

Current Medications:

Drug: _____ Dose: ____ Freq. _____ Since: _____

Drug: _____ Dose: ____ Freq. _____ Since: _____

Information obtained through: Client Report/Family Report/Physician Observation: _____

Results of urinalysis, blood test and/or breathalyzer: _____

I determine this person to (circle one) need / not need medical detox.or hospitalization.

Physician's Signature: _____ Date: _____

Phone Number: (____) _____