



THE MILITARY PROGRAM REFERRAL FORM

To make a referral, please fax or email this form and any available supporting documentation to:
940-381-2236 (confidential) • ubhdentonmilitary@uhsinc.com
Then either call 940-320-8100 (Intake) or 940-765-1285 (secure cell)

PATIENT INFORMATION

Patient: _____ **SSN/Benefits No.: _____ DOB: _____

Patient Cell Phone: _____ MOS or Rank: _____ Duty Station: _____

Diagnosis: _____

Program request: Substance Abuse Crisis Stabilization Safe Haven (psych/MST) Trauma

Branch: _____ Patient to deploy: Yes No Anticipated deployment date: _____

Note any UCMJ actions/discharge plans for SM: _____

Transportation assistance needed? Yes No

****SSN or Benefits Number is required for verification of benefits. A DoD ID number cannot be used for verification of benefits. Providing the SSN or Benefits number assists in expediting the intake process. Thank you!**

REFERRING PROVIDER

Referring behavior health provider: _____

Installation: _____ Department: _____

Non-DSN phone: _____ Email: _____

After-hours emergency contact: _____

Please identify any additional contacts who will receive progress updates during the patient stay. Command updates are automatic. Please note if you prefer we do not update command on this case.*OCONUS facilities - please include country code and complete contact numbers.*

ADDITIONAL CONTACTS

Home Fort/Base Behavioral Health Dept: _____

Nurse Case Manager or Primary Clinical Contact: _____

Non-DSN phone: _____ Fax: _____ Email: _____

First Sergeant: _____ Non-DSN phone: _____

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