



REFERRAL FORM

Consumer Name: _____ D.O.B.: _____

Current Residence: _____ Type of Setting: _____

S.S.#: _____ Marital Status: _____ # of Children: _____

Medicaid #: _____ Medicare #: _____ Other Insurance/Policy #: _____

Other Benefits (e.g. foodstamps, alimony): _____ Religion/Ethnicity: _____

Source of Income(s): _____ Amount(s): _____

Referred by: _____ Referring Agency: _____

Contact Information/phone number: _____ Address: _____

DIAGNOSIS (DSM-IV):

Axis I: _____ DSM Code: _____

Axis I: _____ DSM Code: _____

Axis II: _____ DSM Code: _____

Axis III: _____ DSM Code: _____

Axis IV: _____ DSM Code: _____

Axis V: _____ DSM Code: _____

REASON FOR REFERRAL: (from referral packet and applicant self report):

INPATIENT TREATMENT HISTORY:

<u>Facility</u>	<u>Dates</u> <u>Admit/Discharge</u>	<u>Reason for Admission</u>	<u>Precipitating Factors</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OUTPATIENT/DAY TREATMENT HISTORY:

<u>Facility</u>	<u>Dates</u> <u>Admit/Discharge</u>	<u>Reason for Admission</u>	<u>Precipitating Factors</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMPLOYMENT HISTORY:

Has this individual ever been employed? Yes No If yes, provide details including dates, location and position held:

FAMILY HISTORY:

Is there a history of mental illness in the family? Yes No

If yes, explain:

FAMILY/SUPPORTIVE COMMUNITY:

Emergency Contact: _____

Relationship: _____

Address: _____

Phone: _____

Mental Health History (describe hx of relationships):

Parents: (ages, marital status, health, etc.)

Siblings: (ages, marital status, health, etc.)

Children: (ages, marital status, health, etc.)

Religion: (explain current practice)

PHYSICAL HEALTH:

Of Applicant: (current and past)

Of Family: (include health problems of deceased family members)

MENTAL STATUS EXAMINATION: (indicate presence of the following and describe)

Appearance: (grooming/hygiene) _____

Hallucinations: (auditory/visual, etc) _____

Delusions: _____

Thought Process: _____

Thought Content:

Homicidal/Suicidal:

Sleeping Patterns: _____

Eating Patterns:

Insight/Judgment:

Orientation: (person, place, time)

Memory: (recent/remote)

Description of Symptoms/indicators of decompensation:

Diagnostic Summary:

OTHER COMMENTS/INFORMATION:

Signature: _____

Date: _____