Marion Office
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PATIENT REFERRAL FORM

Referral Name: ______________________________ Today's Date: ____________________

Referral Source Name: ____________________ Company: ____________________ Phone #: ______________
Referral's Date of Birth: ______________ Medicaid #: ______________________________
Referral's Address: ______________________________ City ______________ State ______ Zip ________
Referral's Telephone: (Home) ______________ (Work) ______________ (Cell) ______________
Transportation: ☐ auto ☐ others ☐ walk ☐ public ☐ none
Adjudicated Incompetent: ☐ Yes ☐ No
Legal Guardian Name: ______________________________ Relationship to Individual: ____________________
Guardian's address and phone contacts:
____
____

Referral's Gender: ☐ Female ☐ Male
# of Arrests in last 30 days (if known): ________ # of psychiatric hospitalizations during last two years (if known): __________
Date and Place of Last Hospitalization (if known): ____
Reason for Referral / Presenting Problem(s) (Current Active Symptoms)
____
____
____

Medications (If Known)
____
____
____

Current Mental Health Provider/Doctor: ____
Primary Care Physician and Address: ____
____
____

Entrance Criteria:
A. Client has a Primary Diagnosis of: ☐ Schizophrenia ☐ Schioaffective ☐ Bipolar Disorder ☐ Major Depression with Psychosis ☐ Severe Psychosis NOS ☐ Other ☐ Diagnosis Unknown

AND

B. Exhibits significant functional impairments demonstrated by at least one of the following:

- ☐ Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community or persistent or recurrent failure in the community or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family or relatives
- ☐ Inability to be consistently employed at a self-sustaining level or inability to consistently carry out homemaker roles.
- ☐ Inability to maintain a safe living situation

AND

C. Clients with one or more of the following problems, which are indicators of continuous high service needs:

- ☐ High use of acute psychiatric hospitals or psychiatric emergency services.
- ☐ Persistent or very recurrent severe major symptoms.
- ☐ Coexisting substance use disorder of significant duration (greater than six months).
- ☐ High risk or recurrent history of criminal justice involvement.
- ☐ Inability to meet basic survival needs of food, clothing and shelter and residing in substandard housing, homeless or at imminent risk of becoming homeless.

Signature of Person Making Referral: ____