



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: _____