REFERRAL FORM

Date: Date Placement Required:

Consumer's Name:			
Legal Responsible Person:			
Alias:	Medicaid Number:	Date of Birth:	
Age:	Sex:	Weight (lbs):	Height (inches):

CULTURAL BACKGROUND

Race: ☐White or Caucasian ☐Black or African American ☐Asian/ Pacific Islander ☐Native American ☐ Multi-Racial, explain_________ ☐ Hispanic ☐Other, Please Explain_______

Nationality:
Language:
Religion:
Cultural Needs:

AGENCY INVOLVEMENT

Indicate all agencies currently involved ☐ DSS ☐ LME ☐MCO ☐ DJJ ☐ Vocational Rehab ☐ Other:______

RESIDENT'S PRIMARY REFERRAL SOURCE INFORMATION

Referring Agency: ☐ OJJ	☐ AMH ☐ DSS	☐Other(s)______
Case Manager's Name:	Address:	Telephone Number(s):
Reason for Referral:		

MEDICAL INFORMATION / METHOD OF SCREENING

MEDICAL INFORMATION	METHOD OF SCREENING
Diagnosis DSM-IV Code: Axis I ____________ Axis II ____________ Axis III ____________ Axis IV ____________ Axis V ____________ GAF:	☐ In Person ☐Telephone ☐Other Agency's Staff ☐Individual Service Plan ☐Assessment

Does the individual have a history of:	Does the individual have a history of:	Does the individual have a history of:
Pain: ☐ Yes ☐ No If applicable, please complete a "Pain Assessment"	☐Trauma ☐Self-Injurious Behavior ☐ Assaultive Behavior If applicable, please complete a "Risk Assessment"	☐ Attempted Suicide ☐ Thoughts of Suicide If applicable, please complete a "Suicide Assessment"

Does the individual have Medicaid? ☐Yes ☐No ☐Other:_______________

FOR OFFICE USE ONLY

Disposition 1 Meets basic criteria (Go to Admissions Assessment)
Disposition 2 Does not meet criteria (Go to Discharge/ Transfer Form)

The provider shall retain documentation of the individual's initial contacts and screening for six months, if not admitted. Documentation shall be included in the individual's record if the individual is admitted to the service