



# Referral Form

Referred By: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Email: \_\_\_\_\_ Physician/LPHA Signature: \_\_\_\_\_

**\*\* Please send the most recent Diagnostic Assessment to support Medical Necessity along with referral. \*\***

Referral's Name: \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medicaid: Yes  No  If Yes, Medicaid #: \_\_\_\_\_ MCO: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Alternate # (\_\_\_\_\_) \_\_\_\_\_

Living Situation: Homeless  Lives with Relatives  Boarding Home  Independent

Employed? Yes  No  If Yes, Where/When/How Long? \_\_\_\_\_

Source of Income: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Current Psychiatrist: \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_

Date of Last Hospitalization: \_\_\_\_\_ Where? \_\_\_\_\_

Diagnostic Codes: \_\_\_\_\_ Current Medications (or attach list): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Reason for Referral: (Please check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Basic Living Skills                                 | <input type="checkbox"/> Therapeutic Socialization Skills | <input type="checkbox"/> Mental Illness Management              |
| <input type="checkbox"/> Employment Support                                  | <input type="checkbox"/> Independent Living Support       | <input type="checkbox"/> Prevent Psychiatric Hospitalization    |
| <input type="checkbox"/> Prevocational Training                              | <input type="checkbox"/> Develop Recovery Plan            | <input type="checkbox"/> Improve Self-Confidence/Motivation     |
| <input type="checkbox"/> Interpersonal Skills                                | <input type="checkbox"/> Reduce Negative Symptoms         | <input type="checkbox"/> Prevent Isolation                      |
| <input type="checkbox"/> Medication Support/Education/Compliance             |   | <input type="checkbox"/> Improve Cognitive/Concentration Skills |
| <input type="checkbox"/> Managing Symptoms that interfere with Reintegration |   |   |

Does he/she have a history of violent behavior? Yes  No

If Yes, Explain: \_\_\_\_\_

Does he/she have a history of suicide attempts? Yes  No  If Yes, When? \_\_\_\_\_

Does he/she have a history of alcohol and drug abuse, and/or sexual misconduct? Yes  No

If Yes, Explain: \_\_\_\_\_

Has he/she been convicted of a felony? Yes  No  If Yes, What/when: \_\_\_\_\_