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? _____

*Primary Diagnosis: ☐ Schizophrenia ☐ Bipolar Disorder ☐ Schizoaffective Disorder ☐ Major Depression
Secondary Diagnosis: _____

Current Medications (or attach list): _____

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

___Basic Living Skills
___Employment Support
___Prevocational Training
___Interpersonal Skills
___Medication Support/Education/Compliance
___Managing Symptoms that interfere with Reintegration
___Therapeutic Socialization Skills
___ Independent Living Support
___Develop Recovery Plan
___Reduce Negative Symptoms
___Mental Illness Management
___Prevent Psychiatric Hospitalization
___Improve Self-Confidence/Motivation
___Prevent Isolation
___Improve Cognitive/Concentration Skills

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: _____
_____

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