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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Source:** | | | | | | | |
| **Referring provider/agency**: |  | | **Date**: | |  | | |
| **Referral Contact**: |  | | **Title**: | |  | | |
| **Email**: |  | | **Phone**: | |  | | |
| **Client Information** | | | | | | | |
| **Name**: | **Preferred Name**: | |  | |  | | |
| **DOB**: |  | **County**: | | | |
| **Gender Identity**: | **Pronouns:** | |  | | **Preferred Language**: | | |
| **Insurance**: | **Insurance #**: | |  | |  | | |
| **Home Address**: |  | |  | | **Phone**: | | |
| **Does client have legal guardian**? | | | | | | | |
| **If yes, please list name and phone number and attach copy of documentation**. | | | | | | | |
| **Does client have a Care Coordinator (ICC, ENCC, etc.)**? | | | | If yes, please list name, agency and phone. | | | |
| **Does the client need mental helath or primary care services established?** | | | |  | | | |
| **Please describe the current symptoms and behaviors that necessitate referral for Crisis Respite Services:** | | | | | | |
|  | | | | | | |
| **Name and phone # of outpatient MH provider** (NOTE: Residents are not required to have outpatient services established to be accepted to Crisis Respite. However, we need this information to ensure proper access to care while in our program.): | | | | | | | |
| **Name and phone # of outpatient PCP** (NOTE: Residents are not required to have a PCP established to be accepted to Crisis Respite. However, we need this information to ensure proper access to care while in our program.): | | | | | | | |
| **Primary Mental Health Diagnosis**: | | | | | | | |
| **Additional MH Diagnoses (please list all):** | | | | | | | |
| **Please describe the individual’s goals and recommended length for their respite stay:**  **Please list patients’ current medication prescriber and contact information:**  \*Someone will need to be available to refill medications should refills be needed while patient is admitted\* | | | | | | | |

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| --- | --- | --- |
| **Current Substance Abuse** | | |
| Alcohol Illicit Drugs Prescription Drugs | None |  |
| Substance Type: Usage: Frequency: | | |
| Last Used: Longest Period of Sobriety, if known: Prior Treatment: | Yes | No |
| What are the impacts of substances on client’s Mental Health symptoms?: | | |
| **Historical Behavioral and Risk Data,** | | |
| Does the individual have a history of violence or aggression? | | |
| Does the client have a history of self-harm behaviors? | | |
| Does the client have a history of suicide attempts? | | |
| Does the client have any current legal involvement? | | |