PROGRAM REFERRAL FORM

Individual's Name:

Date of Referral: Click here to enter a date. **Time of Referral:**

Type of Referral: ☐ **Crisis** ☐ **Non Crisis**

If Crisis: Departure Time: Arrival Time: ES Involved/Prescreened?: ☐ Yes ☐ No

Crisis Response Location: Choose an item. **Primary Reason for Referral:** Choose an item.

Description of reason for referral:

Section I: Referral Source Information

Name of Person Making Referral: Name of Agency and/or their Relation:

Source of Referral: Choose an item.

Referral Source Telephone/Email:

Section II: Individual Information

Name of Individual Being Referred:

DOB: Age: SS# (Required): Race/ethnicity: Choose an item. Sex: Choose an item.

Address: Zip Code: City/County:

Type of Residence: Choose an item. # of Residences Within the Past 5 years:

Phone #: Alternate #:

Section III: Diagnoses and Medical (Please list all)

Intellectual and/or Developmental Disability:

Mental Health:

Medical:

Allergies:

Medications: ☐ See attached medication list ☐ No Medications Prescribed

Section IV: Guardian/Authorized Representative

Does Client Have a Guardian?: ☐ Yes ☐ No (If relevant please provide guardianship documents)

If Yes: Name: Relationship:

Address/ Phone/ Email:

Does Client Have an AR?: ☐ Yes ☐ No

If Yes: Name: Relationship:

Address/ Phone/ Email:

Section V: Providers & Emergency Contact

Case Manager Name: CSB: Choose an item.

PROGRAM REFERRAL FORM

Phone #: Email:

Type: ☐ ID/DD CSB ☐ MH ☐ DD Private ☐ DSS (Foster Care) ☐ None

Psychiatrist: Phone: Email:

Behaviorist: Phone: Email:

PCP Name: Phone: Email:

Other (specify): Phone: Email:

Other (specify): Phone: Email:

Emergency Contact: Phone: Email:

Relationship to individual:

Section VI: Insurance (Check all)

☐ MCO Plan Choose an item. ☐ Medicare ☐ Private

☐ None ☐ DD Waiver ☐ DD Waiver Waitlist ☐ Other:

Insurance ID #: MCO #: Medicaid:

Section VII: Hospitalization and Residential History

Psychiatric Hospitalizations in last 3 years (start with most recent):

DATE OF ADMISSION/DISCHARGE	FACILITY	DISCHARGE DISPOSITION (location)

Medical Hospitalizations in last 3 years (start with most recent):

DATE OF ADMISSION/DISCHARGE	FACILITY	DISCHARGE DISPOSITION (location)

Residential Placements in last 3 years (start with most recent):

DATE OF ADMISSION/DISCHARGE	RESIDENTIAL PROVIDER NAME	DISCHARGE DISPOSITION (location)

PROGRAM REFERRAL FORM

Section VIII: School/Vocational

Education Level: Currently Enrolled in School: ☐ Yes ☐ No

Name of School:

Employed: ☐ Yes ☐ No Employer: Employment Status: ☐ P/T ☐ F/T

Type: ☐ With Supports ☐ Without Supports

Section IX: Documentation (Check documents that that can be provided at Intake)

☐ Face Sheet ☐ Psychological ☐ Neuropsychological ☐ Individualized Education Plan

☐ Physical ☐ PPD Test ☐ Medication List ☐ Guardianship/ Power of Attorney Documents

☐ Photo ID ☐ Insurance cards ☐ Other:

Signature of Person Completing Referral/Credentials (please write legibly):

_____

Administrative Use Only:

Disposition:

☐ Accepted for REACH Admission: ☐ DD Population ☐ Expanded Adult MH Population

Coordinator Assigned: _____ **Date**: _____

☐ More information needed to determine if individual is eligible for REACH services

☐ Individual not eligible for REACH

☐ **Individual/Legal Guardian declines on-going REACH services**

Reason for ineligibility:

☐ No diagnosis of DD ☐ SA/Not in full remission

☐ Other: _____

Staff Who Processed Referral:	**REACH Program/Region Receiving Referral:**
Date Received:	**Date Opened in EHR:**
Date of Follow up call:	**Intake Date:**