Client Screening-645.B.1

MHSS SA *IIH* *CrST* *CrINT*

REFERRAL STATEMENT

Referent's Name: _ _____ Gender Male X Female

Age: _____ Emergency: YES ☐non-emergency: ☐ YES

In case of emergency, was there a TDO: ☐ YES NO X SSN: _____

DOB: _____ Medicaid #: _____

□ CCC □ MCO

Name of Caller: _____ Relationship to Referent: _____

Current place of address: _ _____

Phone Number: _____

FOR ALL other services tried / explored within past 30 days (*i.e., CSB, CPS, Stabilization, DSS, Judiciary, or other menta*

_____ This is the client first time in treatment _____

SA IOP Hospitalization required: name and dates of discharge from Psychiatric hospital or other facility *i.e. residential crisis stabilization, ICT or PACT services; psychiatric residential treatment facility; TDO, etc:* This is the client first time in treatment.

Psychotropic Medications prescribed in last 12 months: _____

Method of Contact: Phone In-person Email Fax Date of initial contact_____

Projected date of assessment interview: _____

Anticipated date of admission: _____

Why are services needed? (*Specific symptoms being displayed by referent within past 30 days include frequency, duration, and intensity, i.e. anger problems – describe behavior*).

_____

Referent's Disposition: _____

Location: Richmond City Henrico Chesterfield Hanover Other: _____
Who is the legal guardian(s)
Who referred patient to our agency:
_____
Referral Source Address:
_____

Referral Phone:
_____

Does the client meet eligibility criteria for SA Services Yes _____ No_____

If not was the client/family referred to an appropriate level of care? (Provide location of referral source)

_____

_____

_____

Staff: _____ Date:_ _____