

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:

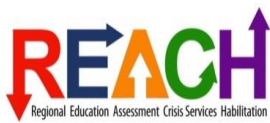
Relationship:

Address/ Phone/ Email:

Section V: Providers & Emergency Contact

Case Manager Name:

CSB: [Choose an item.](#)



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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)



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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

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: _____