

Residential Services

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**Referral Form
(MUST be completed in full)**

Service Requested:

_____ CRR _____ Respite _____ Supportive Housing

Name of Referral: _____

Address: _____

BSU#: _____ Phone: _____

SS#: _____ DOB: _____

Referred by: _____ Agency: _____

Date Referred: _____ Agency Phone Number: _____

** Reason for Referral: _____

Sex: M _____ F _____ Marital Status: M _____ S _____ Div. _____ Wid. _____ Other _____

Size of Household: _____

of Children: _____ Children living with Referral: Yes _____ No _____

Current Living Arrangements:

Temporary _____ Permanent _____ State Hospital _____

Independent _____ Homeless _____ Correctional Facility _____

PCBH _____ With Family _____ Other _____

Has the referral ever been evicted? Yes _____ No _____

Why were they evicted? _____

Is the referral currently employed or are they currently attending school of any type?

Where: _____

Education Completed (Grade) 7 8 9 10 11 12 Other _____

Religious Preference: _____

Income (Source/Monthly): _____ Medical coverage: _____

Source of Transportation: _____

Community Integration: (clubs, volunteer work, etc.)

Most Recent Psychiatric Hospitalization:

Date	Hospital	Primary Symptom
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal/Issues: _____

History of Imprisonment: _____

Is consumer on probation: _____ parole: _____ house-arrest: _____

Parole/Probation Officer: _____ Phone number: _____

Has the referral ever been convicted of a felony? When and What was the charge(s)?

Has the referral ever been convicted for a drug related crime (i.e. possession, selling, etc.)?

When and what was the charge(s)? _____

Substance Abuse: Current: _____ Past History: _____

Substance(s) abused: _____

Are they currently receiving treatment for substance abuse and where:

Physical Disability/Problem(s):

****Date of last Physical:** _____ ****Physical/H&P attached:** _____

*****MUST BE SIGNED BY PHYSICIAN, not CRNP, PA, or RN!!!**

Psychological Testing Available: Y ___ N ___

Date of Testing: _____ By Whom? _____

(Attach copy of psychological to the referral)

Do you Have Diabetes? _____YES _____NO

Can you self-administer your Insulin _____YES _____NO

Would you like to receive Psychiatric care at Community Counseling Center ____YES
____NO

Other Providers Involved: (Psychiatrist, Therapist, PCP, BCM)

**** Current Medications (Attach a separate sheet if necessary):**

Name	Dosage	Frequency	Doctor

Problem List:

Diagnosis including /ICD 10 Code:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

GAF (DLA) _____

*****Referrals will not be accepted without the complete Diagnosis**

/ICD 10 Code and Psychiatrist/Doctor Signature***

Psychiatrist/Doctor Printed Name: _____

Psychiatrist/Doctor Signature: _____ Date: _____

License Number: _____ Expiration Date: _____

History of Fire Setting/Arson? Y _____ N _____

History of Sexual Offenses? Y _____ N _____

History of Suicide Attempts Y _____ N _____

History of Physical Aggression? Y _____ N _____

Towards Others: _____ Towards Self: _____

If Yes Additional Information Related: _____

I understand that the information provided is true and correct to the best of my knowledge.

I acknowledge that my signature gives permission for the CCC staff to discuss my case with the agency/staff person submitting this referral.

Consumer Signature: _____ Date: _____

Referral Signature: _____ Date: _____

FOR OFFICE USE ONLY

Actions taken: