|  |  |
| --- | --- |
| 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.  |
| 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)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

 |
| **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:** |