|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 listNo 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:** |