



DEPARTMENT OF HEALTH ADULT MENTAL HEALTH DIVISION REFERRAL FORM



1. AGENCY REFERRING TO

Name: _____

Address: _____ Phone No.: _____

_____ City _____ State _____ Zip Fax No.: _____

2. SERVICE REFERRING TO:

3. REFERRING AGENCY

Name: _____

Address: _____ Phone No.: _____

_____ City _____ State _____ Zip Fax No.: _____

Name of Contact Person: _____ Phone No.: _____

4. CONSUMER DEMOGRAPHIC INFORMATION

Name: _____ AMHD Ref. No.: _____

Gender: Male Female Birth Date: _____

Type of Current Housing (i.e., 24 HR group home, E-ARCH, homeless, etc.): _____

Address: _____ Home Ph. No.: _____

If homeless, indicate where the consumer can be found _____ City _____ State _____ Zip Cell Ph. No.: _____

1147
Level of care
(ICF,SNF etc)
If applicable _____

5. LEGAL GUARDIAN OR POWER OF ATTORNEY (if applicable).

Name: _____ Relationship: _____

Address: _____ Phone No.: _____

_____ City _____ State _____ Zip

6. DIAGNOSIS

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

7. COVERAGE

Indicate the primary provider for Behavioral Health Services.

AMHD

QUEST

8. FORENSICS

Legal Status: Conditional Release Released on Conditions 406(1) Mental Health Court Jail Diversion

Include a copy of the current conditional release or other current orders, if applicable.

Forensic Coordinator Name: _____

Phone No.: _____

Parole/Probation Officer Name: _____

Phone No.: _____

9. HOSPITALIZED CONSUMERS (if applicable)

Name of Hospital: _____

Projected Discharge Date: _____

10. HEALTH INSURANCE

Name of Health Insurance Company: _____
Attach copy of current insurance card (i.e., HMSA, Kaiser, QUEST etc.)

Insurance Card No.: _____

11. COMMUNITY PSYCHIATRIST

Name: _____

Address: _____ Phone No.: _____

City State Zip Fax No.: _____

12. CASE MANAGEMENT (CM) TEAM INFORMATION

Agency Name: _____

CM Team Name: _____

Phone No.: _____

CM Address: _____

Fax No.: _____

City State Zip

13. Does the consumer require any reasonable accommodation? If so, please explain. (This includes interpreter needs.)

14. OTHER CURRENT SERVICES

Indicate other AMHD services the consumer is currently utilizing: (e.g. rep payee, peer coach, Clubhouse, group home etc)

15. MISCELLANEOUS

List any other pertinent information that this program should know in order to provide appropriate services (e.g. anger triggers and calming interventions, stress tolerance techniques, etc.):

16. PLEASE INCLUDE CURRENT COPIES THE FOLLOWING DOCUMENTS:

- Consent to release information
- Master Recovery Plan
- If there is a guardian, please attach a copy of the order naming the guardian.
- Insurance Card
- Supported Employment additionally requires a psychiatric evaluation

If consumer is forensically involved, please include the following:

- Conditional Release or other Current Court Order
- HCR 20

17.	REFERRAL FORM COMPLETED BY:		
Agency Name: Type of Service:		Print Name	
			Date:
		Signature	

This completes the referral packet for:

- Clubhouse
- Peer Coach
- Homeless Outreach
- Supported Employment: Please include a psychiatric evaluation

Additionally please complete designated attachments for the following services:

- Attachment A: CBCM, Expanded Adult Residential Care Home (E-ARCH), Intensive Out Patient Hospital, Specialized Residential Services, Day Treatment and Aftercare, Therapeutic Living Program,
- Attachment B: Representative Payee Services
- Attachment C: Housing Services: 24 hr. Group Home, 8-16 Hr. Group Home, Supported Housing, Semi-Independent Living, Shelter Plus Care
- Attachment D: This is an additional requirement for all HUD housing
- Attachment E: Hale Imua
- Attachment F: K-Fit

17. To be completed by the program receiving the referral.

PROVIDER DECISION FORM

To: _____ FROM: _____
Referring Agency *Provider and Type of Service*

CONSUMER NAME: _____

DOB: _____ AMHD REF#: _____

Date Referral Received: _____

Date Decision Rendered: Accepted Denied

Service Referred to (POS Provider): _____

If consumer was denied for this service, please complete the rest of this form

Reason for Denial of Referral:

- Consumer refused service
 Does not meet criteria for this service (Please provide explanation):

Consumer may be accepted in the future under the following circumstances:

It is recommended that this consumer pursue alternative placement/treatment with another provider or at another level such as:

Program Contact Person: _____
Print Name

Contact information: _____ Date: _____
Signature

Medical/Clinical Director Review: _____
Print Name

(For applicable services) _____ Date: _____
Signature

Administrative Executive Review: _____
Print Name

_____ Date: _____
Signature