Referral Form

Crisis Residential Program at Natale

Referral Fax Line: (610) 891-7078
Admission Office: (610) 891-7077
After Hours: (610) 891-2583

Unit Director: (610) 891-7331
Administrative Assistant: (610) 891-7071
Monday – Friday: 8:30 am – 5:00 pm

Short-term Residential Treatment Facility for Adults with Mental Illness

Date: ______________________ Time of Call: ______________________

First Name: ____________ Mid Initial: ______ Last Name: ____________ Age: ______

Social Security #: ____________ D.O.B.: ______ Religion: ____________ Race: ______

Address: ______________________ Phone #: ______________________

Emergency Contact: ____________ Phone #: ______ Relationship: ____________

Address: ____

Referral Agency: ____________ Referral Contact: ____________ Phone #: ____________

Referring Psychiatrist: ______________________ Phone #: ____________

ICM Name: ____________ Phone #: ____________ Pager #: ____________

Insurance Information:

Plan Name: ____________ Policy #: ____________ Recipient #: ____________

Primary Care Physician: ______________________ Phone #: ____________

MBH Approval by (Name of Care Mgr.): ______________________ Date: ____________

County Approval by (Name of Co. Rep): ______________________ Date: ____________

Current Medications: List all current medications or treatments. Was patient medication compliant: (Circle one: Y / N)

Medication	Dose	Frequency	Medication	Dose	Frequency

Health Concerns: (List any physical health related issues HEP, TB status, etc.):

____

____

Allergies: ____

Does patient smoke?: (Circle one: Y / N) Special Diet or Restrictions: ______________________________
Current or recent abuse to self for others:

____

Is patient ambulatory?: ____________________ Does patient use any assistive devices?: ______________
Any Recent Medical Consults (list and Explain): ____

____

Functional Assessment: (ADL skills, ability to participate in programming , etc.)

____

____

Reason for Referral:

____

____

Diagnosis:

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: **Current GAF:** **Highest in Past Year:** _________________________________

Substance Abuse (Indicate what substances used, when last used, what frequency)
Alcohol: ______________________________ Marijuana: ______________________
Cocaine: ______________________________ Inhalants: ______________________
Other: ____

Community Agencies Involved:

Agency Name:	Contact Person:	Phone:

If client needs ICM services, has a referral packet been completed and submitted to county. __________ Please note status: ______

____

Treatment History: (Please state what led to hospitalization if coming from in-patient setting): ________________

____

____

____

Any Legal Issues: ____

____

History of Fire Setting: ____

Discharge Planning: After further stabilization at Natale what is the likely community situation that client will be discharge to:

____

If plan is for client to secure a CRR placement, has a CRR packet been submitted to the County and if so what is the status of this referral:

____

What changes are necessary in order for client to transition back to a community residence: ____________________

____

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Please send the following, if available: H&P, consults, med cardex, 3 days of progress notes, and psychiatric evaluation.

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