|  |  |
| --- | --- |
| Referral Source:       | Date of Application / Referral:      |

|  |  |
| --- | --- |
| Client Name:      | DOB:       |
| Address:       | TEL #(s):       |
| Gender Identity:       | Ethnicity:       | Demographic: [ ]  Youth [ ]  Adult |

|  |  |
| --- | --- |
| Health Insurance*(Include insurance type/ID #/secondary insurance etc.)* | Income SOURCE/AMOUNT *(optional- will be used to assess access to resources- for example, housing)* |
|       |  |

|  |  |
| --- | --- |
| Current Clinical Treatment Agency (if Applicable):      | Primary Clinician, if Applicable:      |
| DSM V Diagnosis (es), If Known:      |

Please give an estimate for the following variables for the 180 days prior to the date of referral:

Global Assessment of Functioning (GAF) Code:

Number of Police Contacts:

Number of Shelter Days:

Number of Emergency Department Encounters:

Number of Ambulance Trips:

Number of days not in the Community:

Number of Court Appearances:

Number of Chemical Dependency Crisis Contacts:

Number of Chemical Dependency Detox Contacts:

|  |
| --- |
| **Reason for Applying for Services or Reason for Review: (***include client’s strengths, needs, and goals***):**  |
| **If the consumer is a Youth, provide Parent/Guardian Perception Of Need:**  |

|  |
| --- |
| **Alerts: *List risk factors as they relate to the implementation of the Cross-Systems Service Plan*** |
|  |

**Medical Information**

|  |
| --- |
| **Medical Conditions (include special needs):** |
| **Current Medications** |
| **Medical Provider(s) Name/ #:** |

**Persons Affiliated with the Client**

|  |  |  |
| --- | --- | --- |
| **Name** | **Affiliation** | **Phone Number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Risk Assessment: *Please rate the overall risk of the consumer*

|  |  |  |
| --- | --- | --- |
| 1. None: | [ ]  | Key: |
| 2. Low: | [ ]  | 1. None=Stabilized at baseline; symptoms/stressors well managed by current treatment & supports. |
| 3. Moderate | [ ]  | 2. Low=Experiencing some mental health symptoms and life stressors. |
| 4. High Alert | [ ]  | 3. Moderate=Requires additional community supports and/or is currently experiencing problematic symptoms or stressors. |
| 5. Imminent | [ ]  | 4. High Alert=Requires intensive community support. Absence of intensive supports will likely require hospitalization. |
| 6. Unknown | [ ]  | 5. Imminent=Severe risk, unsafe in the community. Requires secure inpatient program, hospitalization. |

#### Hospitalization: *Total number of days consumer hospitalized/in mental health facility placement 180 days prior to this report:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. 0 days [ ]  | 2. 1-5 days [ ]  | 3. 6-10 day [ ]  | 4. 11-25 days [ ]  | 5. 26+ days [ ]  | Unknown [ ]  |

## Incarceration/Detention: *Total number of days consumer was incarcerated 180 days prior to this report:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. 0 days [ ]  | 2. 1-5 days [ ]  | 3. 6-10 day [ ]  | 4. 11-25 days [ ]  | 5. 26+ days [ ]  | Unknown [ ]  |

# Current Living Situation: PLEASE SPECIFY

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Independent/With Parent or Guardian | [ ]  | 7. Chemical Dependency Inpatient Facility | **[ ]**  |
| 2. Living with relatives/friends | [ ]  | 8. Hospital-Medical Unit | **[ ]**  |
| 3. Mental Health Housing *(specify):*       | [ ]  | 9. Correctional / Detention Facility | **[ ]**  |
| 4. Psychiatric Hospital/Unit | [ ]  | 10. Emergency Shelter | **[ ]**  |
| 5. Chemical Dependency Residential Services | [ ]  | 11. Non-housing (street, park, car, etc.) | **[ ]**  |
| 6. Chemical Dependency Crisis Services | [ ]  | 12. Other *(specify)*:      | **[ ]**  |

# Education Level

|  |  |  |  |
| --- | --- | --- | --- |
| 1. No Formal Education | [ ]  | 4. High School Diploma or GED | [ ]  |
| 2. Some Grade School *(specify last grade completed):*      | [ ]  | 5. Vocational/Tech Training or College Degree: *(specify):*      | [ ]  |
| 3. Some High School *(specify last grade completed:* | [ ]  | 6. Unknown | [ ]  |

**Current Employment Status**

|  |  |
| --- | --- |
| Please Specify | Number Of Hours Worked Per Week |
| 1. Independent Competitive | [ ]  | 1. Over 20 hours | **[ ]**  |
| 2. Assisted Competitive | [ ]  | 2. 11-20 hours | **[ ]**  |
| 3. Intensive & Extended Job Coach Model | [ ]  | 3. 0-10 hours | **[ ]**  |
| 4. Affirmative Business (sporadic/casual, workshop, non-paid)  | [ ]  | 4.Other *(specify):*  | **[ ]**  |
| 5. Unemployed/Disabled | [ ]  |       |
| 6. Unknown | [ ]  |  |  |

# Substance Abuse Impairment Scale

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Abstinent | [ ]  | 4. Dependence | [ ]  | **Specify Drug of Choice and Use Pattern** |
| 2. Use without Impairment | [ ]  | 5. Dependence with Institutionalization | [ ]  |       |
| 3. Abuse | [ ]  | Unknown | [ ]  |

|  |
| --- |
| **General Comments:**  |
| Referent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referent Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Referent Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referent Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |