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Hope House Referral Form

Date	**Time**	**Person making Referral**
Organization		**Contact Number**

Type ICM ☐ ACT ☐ ER ☐ Shelter ☐ BSU ☐ Private Practitioner ☐ Mobile Crisis ☐
Inpatient Psychiatric unit ☐ Magellan ☐ Other

Name: **County Client Case#**

Social Security#: **Birth Date:**

Gender: How do you identify? Male ☐ **Female** ☐ **Please specify):**

Marital Status: Single ☐ **Married** ☐ **Domestic Partner** ☐ **Widowed** ☐

Address: **County:**

Phone: **Number where they can be reached:**

Type of residence **May they return to this residence? Yes** ☐ **No** ☐

Do they feel safe at this residence? Yes ☐ **No** ☐ **If no explain:**

Who else lives in the house?

Is there a known bedbug infestation at this location? Yes ☐ **No** ☐

Homeless? Yes ☐ **No** ☐ **If yes, was 211 contacted? Explain:**

Who is your Mental Health Provider (Who will fund your stay):

Do they have military benefits? Yes ☐ **No** ☐

Name of physical health/pharmacy plan: **ID#**

Do they have any other health plan? No ☐ **Yes** ☐ **Plan name: ID#:**

Does the person want to be admitted to Hope House? Yes ☐ **No** ☐

Are they threatening or violent? No ☐ **Yes** ☐

Do they have a history of violence? No ☐ **Yes** ☐ **Explain:**

Do they have access to weapons? No ☐ **Yes** ☐ **Explain:**

Do they have suicidal ideation? No ☐ **Yes** ☐ **Explain:**

Do they have homicidal ideation? No ☐ **Yes** ☐ **Explain:**

Do they have urges to cut? No ☐ **Yes** ☐ **Explain:**

Are they able to contract for safety? Yes ☐ **No** ☐

Are they a registered sex offender? No ☐ **Yes** ☐

Do they use alcohol? No ☐ **Yes** ☐ **Date of Last use:**

Do they use street drugs? No ☐ **Yes** ☐ **Substance(s)** **Date of last use/Pattern:**

Do they have current legal charges? No ☐ **Yes** ☐ **Explain:**

Name and phone number of probation officer: *

Note: They must agree to sign a release for communication with their probation officer.

Presenting Problem -

Orientation: Person ☐ **Place** ☐ **Time** ☐

Mood: Depressed ☐ **Anxious** ☐ **Irritable** ☐ **Agitated** ☐

Affect: Normal range ☐ **Flat** ☐ **Blunted** ☐ **Expansive** ☐

Speech Normal rate and tone ☐ **Pressured** ☐ **Loud** ☐ **Soft** ☐

Thought Processes
Organized ☐ **Disorganized** ☐ **Tangential** ☐ **Racing** ☐ **Poor Concentration** ☐

Behavior Calm ☐ **Restless** ☐ **Pacing** ☐ **Isolative** ☐ **Poor Impulse Control** ☐

Sleep Good ☐ **Fair** ☐ **Poor** ☐ **Excessive** ☐ **Disrupted** ☐

Appetite: Good ☐ **Fair** ☐ **Poor** ☐ **Increased** ☐

ADL's: Good ☐ **Fair** ☐ **Poor** ☐

Hallucinations: None ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory ☐ Command ☐ **Content:**
Delusions No ☐ Yes ☐ Explain:
Paranoia No ☐ Yes ☐ Explain:
Medical Diagnoses:
Allergies:
Do they have any special dietary needs? No ☐ Yes ☐ **Explain:**
Medications:
Is the client receiving a long-acting injection? No ☐ Yes ☐ **Date last received: Next time it is due:**
Are they diabetic? No ☐ Yes ☐ Are they prescribed Coumadin or warfarin? No ☐ Yes ☐ **Are they insulin dependent? No ☐ Yes ☐**
Name of Prescriber:
Date of most recent lab work for these medications:
Do they need assistance with ambulation? No ☐ Yes ☐ **If yes explain:**
Do they need assistance with ADL's? No ☐ Yes ☐ **If yes explain:**
Do they use a wheelchair? No ☐ Yes ☐ If yes can they propel independently Yes ☐ No ☐
Current Psychiatrist: Date last seen:
Psychiatric Diagnosis(s):
ICM/ACT- Agency name: Agency Phone number:
Case Worker Name: Phone:
Is the caseworker aware of the referral? Yes ☐ No ☐ Date of last contact with case worker:
Date of most recent psychiatric hospitalization:
Additional services:

Advise the client to bring:

- **Insurance cards**
- **Medication in labeled bottles reflecting current dose**
- **Money to cover medication co-pays and/or cigarettes**
- **Bring <u>3 changes of clothing only</u>**
- **Toiletries (No sharp objects)**
- **If prescribed insulin to bring all necessary supplies:**
  - **Insulin in correctly labeled bottles (or written instructions from their prescriber)**
  - **Syringes**
  - **Glucometer (if required to monitor their blood sugars)**
  - **Sliding scale if prescribed insulin coverage based on their blood sugars**

Additional Comments:

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Hope House use only

Date and time referral was received: _____

Staff signature: _____ Date: _____