**REFERRAL FORM- ADULT CRISIS RESIDENCE SUPPORT PROGRAM**

126 Court Street Plattsburgh, NY 12901
Phone: 518 557 4500 Email: crisisreferrals@bhsn.org

| **Basic Client Information** | **Referral Date:** |
|---|---|
| Legal Name: | Preferred Name: |
| (Physical) Address: | |
| County of Residence: | SSN#: |
| Phone #: | DOB: |
| Primary Language: | Ethnicity: |
| Primary Care Provider: | |

| **Financial Information** | | | |
|---|---|---|---|
| Insurance Policy: | | Policy ID: | |
| Policy Holder Name: | | Medicaid #: | |
| Policy Holder DOB: | | Medicare #: | |

| **Referral Information (Please ensure to give direct contact lines, for streamlined communication)** | |
|---|---|
| Individual Making Referral Name: | |
| Representing which Agency/Hospital | |
| Adress: | |
| Phone: | |
| Fax: | |
| Email: | |

| **Mental Health History** | |
|---|---|
| Current Mental Health Treatment? (Where) | |
| Treatment Compliance/<br>Engagement? | |
| Current Medications? | |
| Inpatient Hospitalizations/ Incarceration<br>(Where, Dates of last 90 days, why?) | |

| Health Home Care Management?<br>Community residence/supported housing? | |
|---|---|

| **Known Risk Factors:** | **Present** within 14 days | **Past** More than 14 days ago | **No known History** | Comments- must include most recent date, details, and impact |
|---|---|---|---|---|
| Suicidal (Ideation, attempts) *Include most recent Columbia* | | | | |
| Incarceration/legal involvement | | | | |
| Violence | | | | |
| Physical Harm to others | | | | |
| Destruction of Property | | | | |
| Fire Setting | | | | |
| Sexually abusive | | | | |
| Difficulty meeting basic needs | | | | |
| Outbursts | | | | |
| Command Hallucinations | | | | |
| Drug/alcohol abuse | | | | |
| Frequent Crisis Contacts | | | | |
| Major or Multiple Medical Problems | | | | |
| Non-Suicidal Self Injurious Behavior | | | | |

| **Independent ADLs to include:** | **Yes** | **No** | **Limited with Support** | **Identify Support needs to accomplish ADL** |
|---|---|---|---|---|
| Toileting | | | | |
| Feeding | | | | |
| Bathing | | | | |
| Evacuating in Emergency | | | | |
| Dressing | | | | |
| Taking Medication | | | | |
| Medical Needs | | | | |

| **Crisis Respite Need** | |
|---|---|
| Current acute psychological/emotional change: | |
| Client's current resources/supports: | |
| Current symptoms of distress: | |
| How are current impairments in mood/thought/behavior impacting home, school or the community? | |
| What treatment services have been attempted to aid in managing the above distress so far and what was the client and Support System's response? | |
| Goal for Crisis Respite: | |
| Is Client aware of referral? | |
| In agreement with referral? | |
| Referral does not guarantee placement, and this has been communicated to Client? | |
| Discharge Location: | |

** ALL Referrals will be reviewed by the Program Director and/or Program Coordinator **

Signature of Referral Source: ________________________________________ Date: _________________________________

Reviewed By: ____________________________________________________ Date: __________________________________