

Our Place of Hope Referral Form



Our Place of Hope

Referred By: _____ Agency: _____ Date: _____
Address: _____ Telephone# _____ Fax# _____
Email: _____ Physician/LPHA Signature: _____

Referral's Name: _____ DOB ___ / ___ / ___ SSN _____ - _____ - _____

Medicaid: Yes No If Yes, Medicaid #: _____ MCO: _____

Address: _____ Telephone # (_____) _____
_____ Alternate # (_____) _____

Email: _____

Emergency Contact: _____ Phone: _____ Relationship _____

Living Situation: Homeless Lives with Relatives Boarding Home Independent

Employed? Yes No If Yes, Where/When/How Long? _____

Source of Income: _____ Amount: \$ _____

Current Psychiatrist: _____ Telephone # (_____) _____

Date of Last Hospitalization: _____ Where? _____

*Primary Diagnosis: Schizophrenia Bipolar Disorder Schizoaffective Disorder Major Depression

Secondary Diagnosis: _____

Current Medications (or attach list): _____

Reason for Referral: (Please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Basic Living Skills | <input type="checkbox"/> Therapeutic Socialization Skills | <input type="checkbox"/> Mental Illness Management |
| <input type="checkbox"/> Employment Support | <input type="checkbox"/> Independent Living Support | <input type="checkbox"/> Prevent Psychiatric Hospitalization |
| <input type="checkbox"/> Prevocational Training | <input type="checkbox"/> Develop Recovery Plan | <input type="checkbox"/> Improve Self-Confidence/Motivation |
| <input type="checkbox"/> Interpersonal Skills | <input type="checkbox"/> Reduce Negative Symptoms | <input type="checkbox"/> Prevent Isolation |
| <input type="checkbox"/> Medication Support/Education/Compliance | | <input type="checkbox"/> Improve Cognitive/Concentration Skills |
| <input type="checkbox"/> Managing Symptoms that interfere with Reintegration | | |

Does he/she have a history of violent behavior? Yes No

If Yes, Explain: _____

Does he/she have a history of suicide attempts? Yes No If Yes, When? _____

Does he/she have a history of alcohol and drug abuse, and/or sexual misconduct? Yes No

If Yes, Explain: _____

Has he/she been convicted of a felony? Yes No If Yes, What/when: _____