Our Place of Hope **Referral Form**

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):

___Basic Living Skills
___Employment Support
___Prevocational Training
___Interpersonal Skills
___Medication Support/Education/Compliance
___Managing Symptoms that interfere with Reintegration
___Therapeutic Socialization Skills
___ Independent Living Support
___Develop Recovery Plan
___Reduce Negative Symptoms
___Mental Illness Management
___Prevent Psychiatric Hospitalization
___Improve Self-Confidence/Motivation
___Prevent Isolation
___Improve Cognitive/Concentration Skills

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: _____

_____

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