



## Adult Services Referral Form

Date: Client Name:	Date of Birth:
Funding? Medicaid B: Medicaid B (3): Medicaid B (3) "Additional Services": Medicaid C (Innovations Waiver): Alliance TBI Waiver: Workers' Compensation: MCO TBI Funds: State Funds: Other:	County of Medicaid:
Social Security #:	MCO ID #:
Address:	Home #:  Mobile #:
Client Entitlements (SSI, SSDI, etc.)	Residing County
Does this person have a legal guardian? If so, who?	Does this person have a representative payee? If so, who?
Primary language spoken in home:	Housing status (type and who do they live with):
Referring Staff Name and Agency:	Referring Agency phone #:  Fax #:
<h3 style="color: #4F81BD;">Medical History</h3> <p style="color: #4F81BD; font-style: italic;">Please provide as much information regarding psychiatric and medical history as possible</p>	
Current psychiatric care provider:  Dr. _____  Clinic/Practice name and address:	Current primary care provider:  Dr. _____  Clinic/Practice name and address:



## Adult Services Referral Form

Psychiatric diagnoses (include DSM-V codes):	Current/recurrent medical diagnoses:
Physical Limitations or needs:	Any additional information:

### Psychiatric Provider History

*Please provide as much information as possible*

Is the client currently using any outpatient services?  Yes  No If Yes, please provide details:

Name of Service:

Contact name:

Telephone #

Is the client currently in a hospital?  Yes  No

Has the client had any psychiatric and or medical hospitalizations in the last 5 years?  Yes  No

Date admitted:

Facility/outpatient service:

Date discharged:

Date admitted:

Facility/outpatient service:

Date discharged:

Date admitted:

Facility/outpatient service:

Date discharged:

### Current Medications

Pharmacy name:

Telephone #

**What activities of daily living is client able to do?**

**Why does client need services at this time?**



## Adult Services Referral Form

### Independent Living Skills

*Indicate the level of assistance needed by marking an X under the correct heading*

ACTIVITY	1. I CAN DO MYSELF	2. I NEED TO BE REMINDED	3. I NEED HELP
TOILETING			
LAUNDRY			
TAKING MEDICATIONS			
DRESSING			
LEISURE ACTIVITIES			
MANAGE MY MONEY			
TRANSPORTATION			
HOUSEHOLD CHORES			
GROOMING			
GROCERY SHOPPING			
SIMPLE MEAL PREP			
BATHING			
JOB/DAILY ACTIVITIES			
EATING/DRINKING			
OTHER			

If other, please explain: \_\_\_\_\_

Is there anything else we need to know? \_\_\_\_\_

Please attach the following documentation for this referral:

- CCA or admission assessment
- Discharge summary(s)
- Physician's order/medication history sheet
- Most recent PCP/ISP
- Most recent psychiatric evaluation or neuropsychiatric evaluation
- 6 most recent service notes



## Adult Services Referral Form

### Employment and Volunteer History

Have you ever worked? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you have any interest in working? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please complete the following information:

Place of Employment	Date/Length	Hours/Week	Reason for Leaving
<b>Job Duties:</b>			

Place of Employment	Date/Length	Hours/Week	Reason for Leaving
<b>Job Duties:</b>			

Place of Employment	Date/Length	Hours/Week	Reason for Leaving
<b>Job Duties:</b>			

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*Questions? Contact Toby Prenoveau, MS, CBIS, Intake Coordinator at 919-960-1157,  
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**Fax completed referral and supporting documentation to 919-861-2891**