

|                            |
|----------------------------|
| Date Rec'd _____           |
| Disposition _____          |
| <b>FOR OFFICE USE ONLY</b> |

**Visions Place  
Mental Health and Substance Abuse Residential Treatment  
Referral Form**

**Client Data:**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Last) (First) (Middle)

Current Address: \_\_\_\_\_ Telephone No. \_\_\_\_\_  
(Street)  
(City/State) (Zip Code)

Description of current living situation (e.g., how does individual qualify for homeless services?)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ Martial Status: \_\_\_\_\_ Literate: Yes/No  
 Religion: \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_ Education completed \_\_\_\_\_  
(optional) (optional)

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone No. \_\_\_\_\_  
 City/State/Zip Code: \_\_\_\_\_

**DIAGNOSIS**  
(DSM IV Code)

**(Primary)**

**(Secondary)**

**Axis I** \_\_\_\_\_  
**Axis II** \_\_\_\_\_  
**Axis III** \_\_\_\_\_

**Axis I** \_\_\_\_\_  
**Axis II** \_\_\_\_\_

**AXIS IV** (a) Stressor(s) \_\_\_\_\_ (b) Severity \_\_\_\_\_ (c) Duration \_\_\_\_\_

**AXIS V** (a) Current GAF Score \_\_\_\_\_ (b) Past Year GAF Score \_\_\_\_\_ (if available)

(ENTER TWO DIGIT SCORES FROM 01-90)

Intellectual Level (IQ) \_\_\_\_\_  
Below 70                      70-84                      Above 84

REFERRED BY: Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Agency: \_\_\_\_\_ Date of Referral: \_\_\_\_\_  
 Address: \_\_\_\_\_

Implemented: \_\_\_\_\_  
 Revised and implemented: \_\_\_\_\_ 1

Does the client recognize and accept the need for residential services?    Circle one:    Yes    No

**CLIENT ALERTS**

Does the client have a history of :  
(If yes, please comment below, i.e. most recent time, etc.)

|   | <b>YES</b> | <b>NO</b> |
|---|------------|-----------|
| Fire Setting (Arson, Pyromania)                       | _____      | _____     |
| Serious Sexual Assaultiveness ( Rape, Pedophilia)     | _____      | _____     |
| Serious Assaultive Behavior (Verbal, Physical)        | _____      | _____     |
| Criminal Activity (Include Criminal Procedure Status) | _____      | _____     |
| Outstanding Legal Difficulties                        | _____      | _____     |
| Suicidal Ideation/Gestures/Attempts                   | _____      | _____     |
| Other Behaviors:                                      |            |           |

\_\_\_\_\_

\_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_

**SIGNS OF DECOMPENSATION:**

\_\_\_\_\_

\_\_\_\_\_

| <u>List the type of Substance Abused</u> | <u>Onset of use</u> | <u>Frequency</u> | <u>Quantity</u> | <u>Method of Administration</u> | <u>Date of Last Use</u> |
|--|---------------------|------------------|-----------------|---------------------------------|-------------------------|
| _____                                    | _____               | _____            | _____           | _____                           | _____                   |
| _____                                    | _____               | _____            | _____           | _____                           | _____                   |
| _____                                    | _____               | _____            | _____           | _____                           | _____                   |
| _____                                    | _____               | _____            | _____           | _____                           | _____                   |

**FUNCTIONAL STRENGTHS AND DEFICTS**

| <u>Does Client Currently:</u>   | <u>Independently</u> | <u>Needs Help</u> | <u>Unable</u> | <u>Unknown</u> |
|---|----------------------|-------------------|---------------|----------------|
| Manage personal needs(grooming/hygiene/laundry,etc)?                    | _____                | _____             | _____         | _____          |
| Budgets money?  | _____                | _____             | _____         | _____          |
| Respond appropriately to emergency situations (i.e. fire)?              | _____                | _____             | _____         | _____          |
| Comply with medication regimen?   | _____                | _____             | _____         | _____          |
| Use public transportation and other community resources?                | _____                | _____             | _____         | _____          |
| Plan, shop, and prepare meals?  | _____                | _____             | _____         | _____          |
| How receptive is the client to assistance in these areas?               |                      |                   |               |                |
| Very            Somewhat    Not at all    Unknown ( <b>circle one</b> ) |                      |                   |               |                |

Implemented:  
Revised and implemented:

**SOURCES OF INCOME/FINANCIAL RESPONSIBILITIES** (PLEASE CHECK ALL THAT APPLY)

\_\_\_ No assets or Funding Sources

\_\_\_ **Department of Social Services**

\_\_\_ Active Monthly Amount \_\_\_\_\_ County \_\_\_\_\_ DSS \_\_\_\_\_  
\_\_\_ Pending Application Date \_\_\_\_\_ Telephone No. \_\_\_\_\_ Caseworker \_\_\_\_\_

\_\_\_ **Supplemental Security Income**

\_\_\_ Active Monthly Amount \_\_\_\_\_ County \_\_\_\_\_ SSI Worker \_\_\_\_\_  
\_\_\_ Pending Application Date \_\_\_\_\_ Has Over Payment \_\_\_\_\_ Telephone No. \_\_\_\_\_

\_\_\_ **Social Security**

\_\_\_ Active Type of Benefit (i.e. Disability) \_\_\_\_\_ Claim No. \_\_\_\_\_  
\_\_\_ Previously Received/Inactive \_\_\_ Pending Application Date \_\_\_\_\_ Type Applied For \_\_\_\_\_

\_\_\_ **Payee Status**

\_\_\_ Self \_\_\_ Representative Payee \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City/State) (Zip Code)

\_\_\_ **Food Stamps** \_\_\_ Active Amount: \$ \_\_\_\_\_/Month  
\_\_\_ Pending Application Date \_\_\_\_\_

\_\_\_ **Medical Insurance**

\_\_\_ Medicaid Number: \_\_\_\_\_  
\_\_\_ Medicare/Number: \_\_\_\_\_  
\_\_\_ Other Type: \_\_\_\_\_ Policy No. \_\_\_\_\_

**FINANCIAL RESPONSIBILITIES** (Include monthly amounts) (Include "N/A", if no known financial responsibilities)

Housing cost \_\_\_\_\_ Students Loans \_\_\_\_\_  
Alimony /Child Support \_\_\_\_\_  
Medical Bills/Expenses \_\_\_\_\_ Motor Vehicle \_\_\_\_\_  
Other \_\_\_\_\_

**PREVIOUS RESIDENTIAL SERVICES**

DATE OF ADMISSION                      DATE OF DISCHARGE                      AGENCY  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implemented:  
Revised and implemented:

**INPATIENT HOSPITALIZATIONS** (Psych and Detox)

DATE OF ADMISSION                      DATE OF DISCHARGE                      FACILITY                      SERVICE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE OF INITIAL HOSPITALIZATION \_\_\_\_\_

**OUTPATIENT REHABILITATION/TREATMENT HISTORY** (within the past 12 months)

Location                      Type of Service                      Starting Date                      Ending Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT CLINIC/COUNSELING SOURCE:** \_\_\_\_\_ **Contact:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone No.** \_\_\_\_\_

**Date Linkage Completed:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Status (Circle One)**    **Active**    **Pending**

\_\_\_ **ICM/Case Manager Name:** \_\_\_\_\_ **Telephone No.** \_\_\_\_\_

**Is a referral for ICM/Case Management Services Pending?**    \_\_\_ **Yes**    \_\_\_ **No** \_\_\_\_\_

**Prescribing Psychiatrist:** \_\_\_\_\_

**Telephone No.** \_\_\_\_\_

MEDICATIONS                      DOSAGE                      FREQUENCY

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Compliant?**    \_\_\_ **Yes**    \_\_\_ **No**

**Current Level of Medication Independence:**    \_\_\_ **Supervised**    \_\_\_ **Semi Supervised**    \_\_\_ **Unsupervised**

Implemented:  
Revised and implemented:

**MEDICAL EXAMINATION**

(To be completed by a Physician, Nurse Practitioner or Physician's Assistant)

(A current and legible history and physical examination may be substituted for this page)

Please attach a copy of the last physical examination (within 12 months) or complete the following checklist.

Client's Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_\_

1. Please check ALL that are current or historic medical concerns. (If yes, please comment).

|                            | <b>UNKNOWN</b> | <b>NO</b> | <b>YES</b> | <b>COMMENTS</b> |
|----------------------------|----------------|-----------|------------|-----------------|
| Allergies/Med. Sensitivity | _____          | _____     | _____      | _____           |
| Arteriosclerosis           | _____          | _____     | _____      | _____           |
| Communicable Diseases      | _____          | _____     | _____      | _____           |
| Diabetes                   | _____          | _____     | _____      | _____           |
| Hearing Impairment         | _____          | _____     | _____      | _____           |
| Heart Disease              | _____          | _____     | _____      | _____           |
| Hepatitis                  | _____          | _____     | _____      | _____           |
| History of Cancer          | _____          | _____     | _____      | _____           |
| Hypertension               | _____          | _____     | _____      | _____           |
| Incontinency               | _____          | _____     | _____      | _____           |
| Lung Disease               | _____          | _____     | _____      | _____           |
| Mobility Limitations       | _____          | _____     | _____      | _____           |
| Podiatry                   | _____          | _____     | _____      | _____           |
| Seizure Disorder           | _____          | _____     | _____      | _____           |
| Skin Condition(s)          | _____          | _____     | _____      | _____           |
| Special Diet(s)            | _____          | _____     | _____      | _____           |
| Speech Impairment          | _____          | _____     | _____      | _____           |
| Tuberculosis               | _____          | _____     | _____      | _____           |
| Visual Impairment          | _____          | _____     | _____      | _____           |

Other (please specify): \_\_\_\_\_

For any of the above conditions checked YES, please indicate specific instructions to be followed by the resident.

Signature of Person Completing Form: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Implemented:  
Revised and implemented:

Implemented:  
Revised and implemented: