Reliance Health, Inc.
Multi-Service Referral

POLICY and PROCEDURE: The following form is used for the purpose of sharing information on people requesting services within Reliance Health and the larger Network System. If the referral is internal, this information will be presented to the requested program(s) at the weekly Intake Committee meeting. If this is an external referral, this information will be presented at the weekly Network Central Intake meeting.

I. DEMOGRAPHICS

Name MPI #: DOB: Age:
Address: City: State: Zip:
Phone: Can we leave a message at this number? ☐ Yes ☐ No
Gender: ☐ Male ☐ Female SS#:
Education Level: Primary Language:
Race: ☐ Cauc. ☐ Black ☐ Hisp. ☐ Native-Amer. ☐ Other Does client speak English? ☐ Yes ☐ No

Referring Agency/Person: Date: Phone #:
Reason For Referral:

Diagnosis (**Refer to DSM IV-TR for codes*)

Axis I.
Axis II.
Axis III
Axis IV.
Axis V.

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Current Situation *(Include natural and community supports, risk management and/or safety issues, and current mental status):*

Medical Coverage

Medicaid (T-XIX #): Medicare #:
Private Insurance Carrier & Policy #:
VA Benefits: GA Town:

Income

Employment Income: SSD: SSI: State Supplement:
SAGA: Veterans Benefit: Other:

Medications (indicate compliance) ☐ Yes ☐ No

1. 2.
3. 4.
5. 6.

Known Allergies: Prescribing Physician/APRN: Date:

Next of Kin/Emergency Contact Person

Name: Relationship: Phone #:
Address:
Natural Supports:

History of Psychiatric/Substance Abuse Inpatient Hospitalizations:

History of Risk Factors

☐ History of alcohol/drug use
☐ Sexually assaultive behavior
☐ Prior criminal charges
☐ Access to weapons
☐ Suicidal behavior/threats/gestures/attempts
☐ Homicidal statements/actions
☐ History of arson
☐ Criminal charges pending
☐ Self-destructive behavior
☐ Returning to dangerous environment
☐ Assaults of threats of assault in hospital or community
☐ Non-compliance with Doctors orders re: serious medical condition

Comments to all above checked boxes:

Known stressors/Indicators to decompensation/Interventions:

Services

Service Types	Engaged with Agency/Contact	Level of Care 1 2 3	Services Needed	Date of Referral	Referred to (indicate agency)
Case Management					
Outpatient Psychiatric Services					
Residential/Respite					
Psychological Rehabilitation					
Visiting Nurse					
Work Services/ Employment					
Homeless Outreach					

Recommendations:

Person Completing Form: Date:

Signature/Title

Phone #

☐ Copy given to Intake

☐ Copy given to referred program