Salisbury Behavioral Health, Inc.

PAHrtners Deaf Services

Referral Form

Referral date:				
Referral to:	☐ Crisis Residence	☐ Blended Case Management	☐ Partial Hospital Program	☐ Outpatient
	☐ Resource Coordination	☐ Residential	☐ Peer Specialist	☐ Other: (identify)
Referral Information:				
Name:			E-mail:	
Agency:			County of Referral:	
Address:				
City:			State:	Zip:
Telephone (v/tty):		Fax:		
Relationship of referral source to consumer:				
Consumer Information:				
Name:		**Maiden name:** **(if applicable)**		
DOB:		**SSN:**		
Address:				**Apt. #**
City:			**State:**	**Zip:**
Tel: (H)		**Tel: (W)**		
E-mail:		**Fax:**		
County:		☐ **Male** ☐ **Female**		
Emergency Contact:				
Relationship to consumer:				
Name:			E-mail:	
Agency:				
Address:				
City:			State:	Zip:
Telephone (v/tty):		Fax:		
Diagnosis (DSM-5):				
Financial:				
Insurance Name:		Tel.#:		
Insurance ID #:		Group #:		
MA Recipient #:		Eligibility Verified: ☐ Yes ☐ No		
ACCESS Card: ☐ Yes ☐ No		Card Issue #:		
Other funding source: (identify)				
Representative Payee: ☐ Yes ☐ No		Name:		Tel.#:
Psychiatrist Name:			Tel.#:	
PCP Name:			Tel.#:	
Presenting Problem: (Describe why client is being referred for therapy. Identify behavioral changes.)				
Is consumer agreeable to referral? ☐ Yes ☐ No				

Consumer Name: _____

Risk Assessment: Is consumer at ***current*** risk or do they have a history of:						
Behavior	**Current Risk**		**Describe**	**History**		**Describe**
	Yes	**No**		**Yes**	**No**	
Suicide						
Homicidal						
Violence						
Fire setting +/or Property destruction						
Is the consumer able to contract for safety?						☐ Yes ☐ No
Is the consumer compliant with his/her medication regime?						☐ Yes ☐ No ☐ N/A
Does the consumer have legal charges pending?						☐ Yes ☐ No
Is the consumer currently using drugs and/or alcohol?						☐ Yes ☐ No
If yes, identify drugs of choice:						

Past Mental Health Treatment: (Type of program, location & dates)

Past Drug & Alcohol Treatment: (Type of program, location & dates)
Drug of choice:

***Medical Conditions/Physical Limitations*:** (Identify)	
Is consumer deaf: ☐ Yes ☐ No	If yes, what is preferred method of communication?

Current Medications: (Identify all current meds.)	☐ **See attached medication list**
.	

***Attach the following*:** (Check all attachments)	
☐ Most recent psychiatric evaluation	☐ Most recent physical examination
☐ Psychosocial History	☐ Complete list of current medications
☐ Signed releases of information for any previous treatment involvement/hospitalization	

_____ _____

Signature of person completing referral: ***Date:***

Completed by SBH staff:	**Referral assigned to**:	**Intake appointment scheduled for: (date/time)**

Consumer Name: _____