



Referral Information

Recipient name: _____ DOB: _____
Medicaid Y N Recipient phone: _____
Recipient address & directions: _____

Maiden name: _____ Recipient email: _____
Referred by: _____ Date of referral: _____
Referent phone: _____ Referent agency/relationship: _____
Referent email: _____

How did you hear about Annas Resources? _____
Guardian/Parent name: _____ phone: _____
Guardian/Parent email: _____
Presenting Problem: _____

Diagnosis: _____

Service(s) Requested: _____
Is referral EMERGENT (24 hrs.) URGENT (48 hrs.) ROUTINE (7 days)
Has the individual been served by anyone in the LME 's provider network in the past 60 days?
YES NO LME _____

Insurance (Circle all that apply & record ID #, if applicable) IPRS (no ID #) None
Medicaid _____ Medicare _____
Private Insurance Company Name _____
ID # _____ Group # _____
Send bill to: _____
Which insurance is primary? _____ Secondary? _____
If no insurance, would you like to be considered for a sliding scale payment? Y N

Goals to be addressed: _____

Skills & experience desired in staff: _____

Additional Information: _____

Annas Resources Staff taking referral: _____

If non-clinical staff completing form- STOP HERE and give to Angela or an appropriate QP to finish.

<u>Lethality Assessment</u>	Feelings of harming self or others?	Y	N
If yes: (Circle one)	Ideation only	Ideation & Intent	Ideation, Intent, Plan
		Ideation, Intent, Plan, Means	
Imminent danger to self/others?	Y	N	
If yes, what is plan for safety of self and others?	_____		

NOTE: <u>If you are referring yourself for services</u> AND you feel you may hurt yourself or someone else, call 911 immediately for assistance.			
<u>If you are referring someone else</u> AND you feel that the person is an imminent danger to him/herself or others, call 911 immediately for assistance			
<u>IMPORTANT NUMBERS:</u>	National Suicide Hotline	1-800-SUICIDE	
	Poison Control Center	1-800-222-1222	

Preferred activities & hobbies, etc. _____

What has helped in the past? _____

Duration service expected to last: _____

Group Home candidate? _____

Therapy candidate? _____ ADULT CHILD COUPLES FAMILY OTHER

Current physician & phone: _____

Are you happy with your MD? Y N Comments _____

Medical problems: _____

Current psychiatrist & phone: _____

Are you happy with your psychiatrist? Y N Comments _____

Current therapist & phone: _____

Are you happy with your therapist? Y N Comments _____

Date of Last Mental Health/Substance Abuse Hospitalization _____

Name & address of hospital _____

Substances Used:	Alcohol	Marijuana	Crack/Cocaine	Ecstasy
	Heroin	Amphetamines	Hallucinogens	Inhalants
			Barbiturates	

Involved with AA, Al Anon, NA, etc? Y N

Transfers Only If transferring from other agency, why? _____

What service are you currently receiving? _____

How many hours per week, do you receive? _____ hrs/week.

What would you like to change about current services? _____

Screening Criteria Met? YES NO



Demographic Information: This information will be used to analyze the agency's degree of cultural competency and help us respond more efficiently to the diversity of our clients. There may be some information you do not want to answer. It is okay to leave something blank.

Age: _____ **Ethnicity:** _____

Race: (Please circle only one) White alone Black/African American alone
 American Indian & Alaska Native alone Native Hawaiian or Pacific Islander alone
 Some other race alone (which race? _____)
 Two races Three or more races

Gender: M F Other _____

(Indicate if gender identity is different from initial gender)

Sexual Orientation: Lesbian Gay Heterosexual Bisexual Transsexual
 Questioning Sexual Orientation

Religion: _____

Marital status: Single Married Widowed Divorced Separated

Citizenship: US Other _____

Employment: Y N **Hours:** Part time Full time

Homelessness: Are you currently homeless? Y N

At risk for homelessness? Y N

Veteran status Y N

Primary language _____

Education: (circle one) Grade School Some HS HS Graduate Some college
 College Graduate Some Graduate School Graduate Degree

Family Income: _____

Rurality: Do you live on a bus line? Y N In a rural area? Y N

HIV Status: Are you HIV Positive? Y N Unknown

Immigrant Status: Have you recently moved into this country? Y N

Are you Hard of Hearing or Deaf? Y N

Do you have an Acquired Traumatic Brain Injury? Y N Age acquired _____

Are there any questions we can answer for you at this time? _____

Annas Resources Staff completing referral: _____

Office Use Only: Date Entered for Referral Tracking Purposes _____

Assigned to: _____ Date assigned _____

Instructions for Follow up: _____

Signature of QP or Therapist Assigned _____

Date of Initial Contact _____

Initial NC Topps Date _____

Diagnostic Assessment Scheduled: _____

Assessment offered within 2 weeks of referral date? Y N

Introductory PCP & authorization sent electronically on _____

Or ORF 2 sent on _____

Follow-up Contact Log

Date	Time	Method of Contact	Result	Next Step	Initials
Ex: 1/26/09	8:30 am	Telephone call to referent	No answer- left message requesting call back.	Try again this afternoon	SB