



MENTAL HEALTH REFERRAL FORM

Date Completed: _____

MH CENTER

VENTURES PROS

INDIVIDUAL INFORMATION					
Name: _____		DOB: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address: _____			Phone: _____ (H) _____ (C)		
Email: _____					
Ethnicity:	<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian	<input type="checkbox"/> Other (specify)
Primary Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> ASL	<input type="checkbox"/> Other (specify)	
Marital Status:			Are you a Veteran?		
Highest Level of Education Completed:		<input type="checkbox"/> High School	<input type="checkbox"/> GED	<input type="checkbox"/> Some College	<input type="checkbox"/> Degree
Religion:					
Current Legal Status:	<input type="checkbox"/> None	<input type="checkbox"/> Parole	<input type="checkbox"/> Probation	<input type="checkbox"/> Pending	
Living Arrangement:					
Emergency Contact:		Relationship:		Phone:	
Have you ever been a client of Rochester Rehabilitation in the past: <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, what program(s): _____					
Do you have a family member or significant other receiving mental health services at Rochester Rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No					

INSURANCE INFORMATION			
Social Security Number:			
Medicaid Number (sequence #):		County of Responsibility:	
Medicaid Option Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: <input type="checkbox"/> Blue Choice Option <input type="checkbox"/> MVP <input type="checkbox"/> Fidelis		
Medicare Number:		<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> Medicare Part B
Medicare Part D Number:		Provider:	
Other Insurance Provider:		Other Provider Number:	
Are you enrolled in any Medicaid Waiver Program? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide contact information:			
Employment Status:		Occupation:	
Do you have a Medicaid spend-down: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, spend-down amount: \$			
Do you participate in Medicaid buy-in? <input type="checkbox"/> Yes <input type="checkbox"/> No			



CURRENT SERVICE PROVIDERS

	Name/Address	Phone	Fax
Primary Care Medical Provider			
Therapist			
Psychiatrist			
Case Manager			
Residential Contact			
Other Psychiatry Services			

PERSONAL GOAL INFORMATION

What are your life goals?

What barriers to those goals are you working to overcome?

What symptoms do you experience (check all that apply):

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Dangerous to self or others | <input type="checkbox"/> Depression/Mania | <input type="checkbox"/> Confusion/Disorientation | <input type="checkbox"/> Non-compliant with medications |
| <input type="checkbox"/> History of suicide, danger to self | <input type="checkbox"/> Anxiety/Agitation | <input type="checkbox"/> Poor judgment/impulsivity | <input type="checkbox"/> Problems with eating |
| <input type="checkbox"/> Self harm (self-injurious behaviors) | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Problems with sleeping |
| <input type="checkbox"/> Homicidal – danger to others | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Socially withdrawn | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Ritualistic behavior | <input type="checkbox"/> Severe mood swings | <input type="checkbox"/> Sexual inappropriateness | <input type="checkbox"/> Other: |

Describe your ability to participate, interact, and accept responsibility in group situations:

PSYCHIATRIC DIAGNOSIS

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Previous psychiatric hospitalizations:

Admission/Discharge dates:

Previous Outpatient programs:

Admission/Discharge dates:

Current Medications: _____

Chronic Medical Conditions: _____

Special Needs: _____ Allergies (Foods or Medications): _____



DRUG AND ALCOHOL SCREENING

Please give a brief overview of your experience with drugs and alcohol: _____

Age of first use: _____

Substance(s) used: _____

Date of last use: _____

Substance(s) used: _____

Have you ever received treatment for addiction and if so, please give provider and dates of service: _____

Are you currently receiving substance abuse treatment or involved in self-help groups? If yes, please specify: _____

REQUIRED SERVICES

What mental health services might be helpful to you? Please check all that apply:

- MH Center only: individual counseling and psychotherapy, group therapy, and medication evaluation/consultation for adults that experience barriers to functioning in their everyday lives.
- PROS Continued Recovery Support (CRS): classes, groups, and skills development opportunities to improve self care, life management, community living, social and work readiness skills.
- PROS Clinical Treatment: working with a prescriber, nurse, and therapist on medication and symptom management. (Must receive other PROS services as well).
- PROS Intensive Rehabilitation (IR): short term service to work intensely on a rehabilitation goal such as achieving a life role or intensive symptom management to avoid losing a life role.
- PROS Ongoing Rehabilitation Support (ORS): vocational support for individual currently employed at least 10 hours per week.

Please mail or fax the information requested below along with the Referral Form to:

Mental Health Center Intake Coordinator
 Rochester Rehabilitation
 1000 Elmwood Avenue | Rochester NY 14620
 Phone: 585.271.2520 ext. 1594 | Fax: 585.286.9236

OR

Ventures PROS Intake Coordinator
 Rochester Rehabilitation – Ventures PROS
 975 Elmwood Avenue | Rochester NY 14620
 Phone: 585.256.3430 ext. 1132 | Fax: 585.286.9226

Referring Individual (please print): _____

Signature: _____

Referring Agency: _____

Phone: _____

Email: _____

Please include:

- Clinical summary or current psychosocial history
- Current treatment plan (if applicable)
- Copies of insurance cards
- Current medication log (if applicable)
- Other psychiatric services client receives (for example, outpatient group)