

Ventures IPRT
Referral Form

Individual's Name: _____ DOB: _____

Address: _____ Zip _____

Phone (_____) _____ SS# _____

Medical insurance _____ Number _____

Monthly income: _____ Source I _____ Source II _____

Medicaid spend-down Yes _____ No _____ If yes, spend-down amount _____

Will individual require transportation assistance? Yes _____ No _____

Emergency contact person: _____ Phone: (_____) _____

Psychiatric Information:

Psychiatric Diagnosis (Current DSM-IV, numerical designation)

Axis I _____, _____

Axis II _____, _____

SPMI Yes _____ No _____

Current medications and dosage _____

Signs & symptoms of decompensation _____

History of aggression or assault _____

Significant legal issues. Are they court mandated to be in treatment program? _____

For Scheduling and Billing purposes, please list what other psychiatric services the client receives:

Clients need to be psychiatrically stable and ready to focus on rehabilitation goals (examples: work, living, learning, and social). Therapeutic issues will be redirected to the therapist. It is not the role of the practitioner at Ventures to do therapy.

Medical Information:

List any physical conditions/special needs that may impact the rehabilitation process: _____

Contacts: Name Address Phone Number

Psychiatrist _____

Primary Care Physician _____

Case Manager _____

Primary Therapist _____

Residential _____
Outpatient Program _____
Vocational Services _____
Other _____

Reason for Referral for IPRT Services:

Of these four areas, which one does the consumer want to pursue? If more than one, please prioritize:

Learn _____ Live _____ Social _____ Work _____

List any relevant information on goal environment checked above.

Current: _____

Past: _____

Factors that indicate readiness for IPRT Services: _____

Expected Rehabilitation Outcome: _____

Please submit the following with the Referral Form:

CLINICAL SUMMARY OR CURRENT PSYCHOSOCIAL HISTORY

Please mail or fax referral to:

Ventures IPRT, 975 Elmwood Avenue, Rochester NY 14620

Phone (585) 256-3430

FAX (585) 935-7861

Referring Agency: _____

Address: _____

Referring individual's signature: _____

Licensed practitioner's signature: _____

(if different than above)

Please include:

- _____ Other psych. services client receives (ex: outpatient group)
- _____ Psychosocial history
- _____ Licensed practitioner signature
- _____ DSM-IV Diagnostic Number