 **EHS Referral Form**

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| **DATE OF REFERRAL:** |  |
| **PROGRAM(S) DESIRED:** |
| **Community Mental Health:** |[ ]  **Mental Health Skill-building Services** |
| **Addiction & Recovery** |[ ]  **Partial Hospitalization** |[ ]  **Intensive Outpatient** |[ ]  **SA/MH Outpatient** |[ ]  **Case Management** |[ ]  **Peer Recovery** |
| **AREA OFFICE DESIRED** |
|[ ]  **Lynchburg** |[ ]  **Martinsville** |[ ]  **New River Valley** |[ ]  **Roanoke** |
| **REFERRAL SOURCE** |
| **REFERRING PARTY NAME:** |  | **REFERRING AGENCY:** |  |
| **MAILING ADDRESS:** |  |
| **TELEPHONE NUMBER:** |  | **E-MAIL ADDRESS:** |  |
| **If Self-Referral, how did you hear about EHS:** |  | **If receive Waiver Services, which type:** |  |
| **CLIENT DEMOGRAPHIC, INSURANCE, AND DIAGNOSTIC INFORMATION** |
| **Name:** |  | **Date of Birth:** |  |
| **Address:** |  |
| **Home Phone:** |  | **Gender:** |  |
| **Cell Phone:** |  | **Race:** |  |
| **Work Phone:** |  | **Marital Status:** |  |
| **Social Security Number:** |  | **Medicaid Number:** |  |
| **Additional/Other Insurance/Private Pay:** |  | **Insurance Number:** |  |
| **DIAGNOSTIC INFORMATION** |
| **Diagnostic Code** | **Diagnostic Description** |
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| **LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/POA INFORMATION** (If Applicable) |
| **Name:** |  | **Phone:** |  |
| **PREVIOUS HIGHER LEVEL OF CARE/HOSPITILIZATION** (If Applicable) |
| **Name:** |  |
| **Address:** |  |
| **Phone**: |  | **Fax:** |  |
| **SUBSTANCE ABUSE INFORMATION** (For ARTS Services only) |
| **Date of Last Use:** |  | **Frequency of Use:** |  |
| **Amount of Use:** |  | **Route of Use:** |  |
| **Substance Used:** |  |
| **Previous Treatment History:** |  |
| **MENTAL HEALTH SKILL-BUILDING** (Client must meet all 5 criteria-For MHSS Only) |
| Is the primary diagnosis schizophrenia/other psychotic disorder, Major Depressive Disorder-Recurrent, or Bipolar I or II? |[ ]  YES |[ ]  NO |
| If the primary diagnosis is not one of the above, has a physician documented any other mental health disorder within the last year to include all of the following: |[ ]  YES |[ ]  NO |
| Serious Mental Illness (SMI), Severe and recurrent disability, Functional limitations in the client’s major life activities which are documented in the client’s record; and client requires individualized training in order to achieve or maintain independent living in the community. |
| Does the client require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management? |[ ]  YES |[ ]  NO |
| Does the client have a prior history of any of the following? |[ ]  YES |[ ]  NO |
| Psychiatric hospitalization, Crisis Stabilization Services, Intensive Community Treatment (ICT), Program of Assertive Community Treatment (PACT) services, Placement in a psychiatric residential treatment facility (RTC Level C); or Temporary Detention Order (TDO) evaluation as a result of decompensation related to serious mental illness. |
| Has the client had a prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the last 12 months? |[ ]  YES |[ ]  NO |
| **PEER SUPPORT SERVICES** |
| **Does client require recovery-oriented assistance and support?** |[ ]  YES |[ ]  NO |
| **Does client demonstrate moderate to severe functional impairment because of SUD diagnosis that interferes with or limits performance?** |[ ]  YES |[ ]  NO |
| **NOTES:** |
|  |
| **Person Taking Referral (if applicable):** |  |

**EHS Office Use: \* Please attach additional information as needed**

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| **Date Referral Received:** |  | **Date Insurance Confirmed:** |  |