 **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:** |  |