Crisis Stabilization Services Referral

Date of Referral:_____

Referral Source:_____ **Phone #:**_____

Individual Information (Please Print)

Name:_____ Gender: ☐ M ☐ F

DOB:___/____/_____ Social Security #:_____ Insurance Provider:_____

Parent/Guardian:_____ Medicaid #:_____

Address:_____

Type of Housing (i.e.: homeless, shelter, group home, etc.)_____

Home #:_____ Cell #: _____ Email #:_____

PCP Name/Clinic:_____ Office #:_____

Reason for Referral:_____

_____

Currently in Crisis ☐ Yes ☐No: If yes please explain:_____

Current/Presenting Problems: *(presenting needs/situation including psychiatric and medical problems, current medications, and history of medical care)* **Check all that apply:**

☐ Easily Agitated	☐ Withdrawn	☐ Physical Abuse Issues	☐ Sexual Abuse Issues
☐ Trauma	☐ Thoughts of Suicide	☐ Stealing	☐ Housing Issues/Homelessness
☐ Destructive	☐ Depressed	☐ Trouble with Law	☐ Medication Compliance
☐ Social Phobias	☐ Homicidal Ideations	☐ Alcohol/Drug Use	☐ Self-Mutilation
☐ Physically Aggressive	☐ Mania/Hypomania	☐ Fire Setting	☐ Irritable
☐ Having Trouble	☐ Eating Problems	☐ Verbally Aggressive	☐ Lack of Food/Resources
☐ Keeping Employment	☐ Sleeping Problems	☐ Anger Outbursts	

Additional Comments:_____

_____

_____

_____

Have Mental Health Services been received before? ☐Yes ☐No If Yes, Describe: _____

Eligibility and Documentation (At least ***two*** of the following criteria must be met to qualify for services**):**

I. In order to receive crisis stabilization services, the individual must meet at least **one** of the following criteria:
   - **a.** Yes ☐or No ☐-- Is the individual experiencing marked reduction in psychiatric, adaptive, or behavioral functioning?
   - **b.** Yes ☐or No ☐ – Is the individual experiencing extreme increase in emotional distress?
   - **c.** Yes ☐or No ☐ – Is the individual in need of continuous intervention to maintain stability?
   - **d.** Yes ☐or No ☐ – Is the individual causing harm to self or others?

II. The individual must be at risk of at least **one** of the following:
   - **a.** Yes ☐or No ☐-- Psychiatric hospitalization
   - **b.** Yes ☐or No ☐-- Emergency ICF/IID placement
   - **c.** Yes ☐or No ☐-- Disruption of community status (living arrangement, day placement, or school)
   - **d.** Yes ☐or No ☐-- Causing harm to self or others

Referral Assigned:_____ **Date:**_____

Scheduled Assessment Date and Time:_____

Assessment Completion Date: _____