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☐ Easily Agitated	☐ Withdrawn	☐ Physical Abuse Issues	☐ Sexual Abuse Issues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:____

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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: __________________________________