Hope House Referral Form

3606 Hecktown Rd. Bethlehem, PA 18020
Phone: 610-882-2008 Fax: 610-882-2009
www.hopehouse-rhd.org

Date	Time	Person making Referral
Organization		Contact Number
Type ICM □ ACT □ ER □ Shelter □ BSU □ Private Practitioner □ Mobile Crisis □ Inpatient Psychiatric unit □ Magellan □ Other		

Demographics

Name: County Client Case#
Social Security#: Birth Date:
Gender: How do you identify? Male □ Female □ (Please specify):
Marital Status: Single □ Married □ Domestic Partner □ Widowed □
Address: County:
Phone: Number where they can be reached:
Type of residence May they return to this residence? Yes □ No □
Do they feel safe at this residence? Yes □ No □ If no explain:
Who else lives in the house?
Is there a known bedbug infestation at this location? Yes □ No □
Homeless? Yes □ No □ If yes, was 211 contacted? Explain:

Insurance

Who is your Mental Health Provider (Who will fund your stay):
Do they have military benefits? Yes □ No □
Name of physical health/pharmacy plan: ID#
Do they have any other health plan? No □ Yes □ Plan name: ID#:

Admission Criteria

Does the person want to be admitted to Hope House? Yes □ No □
Are they threatening or violent? No □ Yes □
Do they have a history of violence? No □ Yes □ Explain:
Do they have access to weapons? No □ Yes □ Explain:
Do they have suicidal ideation? No □ Yes □ Explain:
Do they have homicidal ideation? No □ Yes □ Explain:
Do they have urges to cut? No □ Yes □ Explain:
Are they able to contract for safety? Yes □ No □
Are they a registered sex offender? No □ Yes □

Substance Use

Do they use alcohol? No □ Yes □ Last use: Amount
Do they use street drugs? No □ Yes □ Substance(s)
Pattern of use last 7 days:

Legal Issues

Do they have current legal charges? No □ Yes □ Explain:
Name and phone number of probation officer: *

Note: They must agree to sign a release for communication with their probation officer.

Revised 9/10/18

Presenting Problem

Mental Status **Place a check next to the following symptoms or behaviors that apply**

Orientation: Person □ Place □ Time □
Mood: Depressed □ Anxious □ Irritable □ Agitated □
Affect: Normal range □ Flat □ Blunted □ Expansive □
Speech Normal rate and tone □ Pressured □ Loud □ Soft □
Thought Processes **Organized □ Disorganized □ Tangential □ Racing □ Poor Concentration □**
Behavior Calm □ Restless □ Pacing □ Isolative □ Poor Impulse Control □
Sleep Good □ Fair □ Poor □ Excessive □ Disrupted □
Appetite: Good □ Fair □ Poor □ Increased □
ADL's: Good □ Fair □ Poor □
Hallucinations **None □ Auditory □ Visual □ Tactile □ Olfactory □ Command □** **Content:**
Delusions No □ Yes □ Explain:
Paranoia No □ Yes □ Explain:

Medical Information

Medical Diagnoses:
Allergies:
Do they have any special dietary needs? No □ Yes □ **Explain:**
Medications:
Is the client receiving a long-acting injection? No □ Yes □ **Date last received: Next time it is due:**

Are they diabetic? No □ Yes □ **Are they insulin dependent? No □ Yes □**

Are they prescribed Coumadin or warfarin? No □ Yes □
Name of Prescriber:
Date of most recent lab work for these medications:

Do they need assistance with ambulation? No □ Yes □ **If yes explain:**
Do they need assistance with ADL's? No □ Yes □ **If yes explain:**
Do they use a wheelchair? No □ Yes □
If yes, are they able to propel it and transfer in and out of it independently? Yes □ No □ **If no explain:**

Current Services

Current Psychiatrist:	**Date last seen:**
Psychiatric Diagnosis(s):	
ICM/ACT- Agency name:	**Agency Phone number:**
Case Worker Name: Phone:	
Is the caseworker aware of the referral? Yes □ No □	**Date of last contact with case worker:**
Date of most recent psychiatric hospitalization:	
Additional services:	

Advise the client to bring:

- **Insurance cards**
- **Medication in labeled bottles reflecting current dose**
- **Money to cover medication co-pays and/or cigarettes**
- **Bring 3 changes of clothing only**
- **Toiletries (No sharp objects)**
- **If prescribed insulin to bring all necessary supplies:**
  - **Insulin in correctly labeled bottles (or written instructions from their prescriber)**
  - **Syringes**
  - **Glucometer (if required to monitor their blood sugars)**
  - **Sliding scale if prescribed insulin coverage based on their blood sugars**

Additional Information

_____
_____
_____
_____
_____
_____

Hope House use only

Date and time referral was received: _____

Staff signature: _____ Date: _____