lower shore clinic Go-Getters

Crisis Services Referral Form

208 E Main Street, Ste C
Salisbury, MD 21801
P: 410-341-3420x1 F: 410-651-4872
referral@lowershoreclinic.org

Client Name: _____ Date of Referral: _____

Date of Birth: _____ Social Security Number: _____

Sex: ☐ Male ☐ Female Gender Identity: _____ Currently Inpatient: ☐ Yes ☐ No

Current Living Arrangement: (If inpatient, living arrangement prior to hospitalization)

☐ Lives Alone ☐ Lives with family/friend ☐ Homeless ☐ RRP ☐ Other _____

If Inpatient: Can Return to this arrangement upon discharge ☐ Yes ☐ No

Address: _____

Mobile Phone: _____ Home Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed # Children _____

Ethnic Group: ☐ African American ☐ Hispanic ☐ White Non-Hispanic ☐ Asian/Pacific Island

☐ American Indian/Alaska Native ☐ Other _____

Emergency Contact: Name: _____ Relationship: _____

Address: _____

Phone Number: _____

Referral Source Name: _____ Contact Number: _____

Agency: _____ Phone Number: _____

Psychiatric Provider: _____ Phone Number: _____

Release/Authorization:

I, _____, authorize the release/exchange of all available information between the following agencies/individuals to support my application to Go Getters. This includes information that may pertain to denial or termination, including the reason for these actions, and when appropriate, discharge plans.

(Please provide names, agencies, and contact information)

Emergency Contact: _____

Mental Health Provider: _____

Somatic Provider: _____

Entitlement Agency: _____

Lab: _____

Other Agency: _____

Other Agency: _____

Friend: _____

Friend: _____

I understand that application for Residential Crisis Services is being made on my behalf and agree to this referral for services.

Signature of Applicant: _____ Date: _____

Signature of Witness: _____ Date: _____

Current Psychiatric Diagnoses: **ICD 10 Code**

Primary: _____ _____

Secondary: _____ _____

Tertiary/Additional: _____ _____

_____ _____

Medical: _____ _____

_____ _____

Social Elements Impacting Diagnosis: ☐ Financial ☐ Social Environment ☐ Occupational ☐ Legal

☐ Primary Support Group ☐ Housing ☐ Homelessness ☐ Access to Healthcare

Please describe the pertinent precipitants and the nature of the current crisis: _____

_____

_____

_____

_____

History of Present Illness: _____

_____

_____

Presenting Problems: (Check all that apply and provide elaboration)

☐ Visual or Hearing Impairment: Explain _____

☐ Physical Disability: Explain _____

☐ Chronic Health Problems/Somatic Issues _____

☐ Special Dietary Needs _____

☐ Drug or Alcohol Abuse Explain: _____

_____

☐ Social/Interpersonal Conflicts, Including Marital and Family Problems _____

_____

☐ Hallucinations/Delusions _____

☐ Depression/ Mood Disorder _____

☐ Suicide Threat/Attempts/Self Harm, Include date of most recent occurrence _____

_____

☐ Homicidal Threat/Attempt _____

_____

☐ Violent/Assaultive Behavior _____

_____

☐ Other: Include specific detail _____

_____

Access to Weapons: ☐ Yes ☐ No ☐ Unknown If yes, please list _____

Psychiatric Hospitalization History **Number of Hospitalizations (Lifetime) _____**

3 Most Recent Hospitalizations

Institution _____ Date _____

Institution _____ Date _____

Institution _____ Date _____

Reasons for hospitalizations _____

_____

_____

Substance Use: - Did drugs or alcohol have a significant impact on current crisis? ☐ Yes ☐ No

As a result of drinking has the client ever experienced: Seizures ☐ Yes ☐ No **Blackouts** ☐ Yes ☐ No

"DT's" ☐ Yes ☐ No **Withdrawal** ☐ Yes ☐

Additional Information: _____

Forensic Status ☐ No Forensic Status ☐ Conditional Release ☐ Parole/Probation ☐ Not Criminally Responsible

Conditions of Probation/Parole/ Pending Charges _____

_____

_____

Probation/Parole Contact Information _____

Level of Functioning: Able to Read ☐ Yes ☐ No Able to Write ☐ Yes ☐ No

Highest grade completed, if known _____ Special Education ☐ Yes ☐ No

Activities of Daily Living: _____

Able to attend to own personal hygiene and basic physical needs ☐ Yes ☐ No

Interpersonal Skills: _____

Currently Employed ☐ Yes ☐ No If yes, please provide details: _____

_____

Any Other Special Needs or Considerations (Please List with details) Support and Recovery Groups, Religious Considerations, appointments, etc.: _____

_____

_____

Current Medical Concerns: _____

_____

Currently Compliant with Outpatient Mental Health Appointments ☐ Yes ☐ No

Provider: _____

Currently Medication Compliant: ☐ Yes ☐ No ☐ With Reminders

Medications Currently Prescribed, if known, as well as who prescribed. You may attach a separate sheet:

Note: Current medications and medication monitoring orders are required if Crisis staff are to monitor client medications- Please attach copies of medication orders/prescriptions. Include over the counter medications.

_____

_____

_____

_____

Brief Psychosocial History (Please include significant individuals, family members, and level of involvement:

_____

_____

_____

Victim of Assault, Sexual Assault, Violent Crime, other Trauma, please explain: _____

_____

_____

Current Natural Supports, including family and significant others: _____

_____

Current Entitlement Information

☐ Social Security	Amount _____	☐ PAA	Amount _____
☐ SSI	Amount _____	☐ VA Benefits	Amount _____
☐ SSDI	Amount _____	☐ Salary/Wages	Amount _____
☐ Other Income: Type: _____		Amount: _____	
☐ Medicaid	ID Number _____	☐ Medicare	ID Number _____

Client Needs: **1.** _____

2. _____

3. _____

Has the Client Been Medically Cleared by a Physician or Hospital ED and Deemed Appropriate for Admission to Non-Medical Residential Crisis Services : ☐ Yes ☐ No **Please attach Medical Clearance**

Physician or Facility Issuing Clearance: _____ **Contact Number:** _____

Allergies: _____

Date of Medical Evaluation: _____

Contact 410-341-3420x1 with any questions
Submit to referral@lowershoreclinic.org or via fax at 410-651-4872