EvergreenHealth

REFERRAL FOR:
IN-HOME MENTAL HEALTH SERVICES

REFERENT NAME (PERSON MAKING REFERRAL):	REFERRAL DATE:
AGENCY:	PHONE #:

CAN CLIENT CONSENT FOR SELF? ☐ YES ☐ NO

IF NO, DOES CLIENT HAVE A GUARDIAN/(D)POA? ☐ YES ☐ NO

GUARDIAN/POA- NAME: _____ PHONES - HOME: _____

MAILING ADDRESS: _____ CELL: _____

_____ WORK: _____

IS CLIENT AGREEABLE TO SERVICES? ☐ YES ☐ NO

DEMOGRAPHICS:

NAME: _____ ☐ Male ☐ Female DOB: __/__/____

ADDRESS: _____ SSN: _____

APT # / NAME: _____ PHONE: _____

CITY, ZIP: _____ RACE: _____

MARITAL STATUS: ☐ S ☐ P ☐ M ☐ W ☐ D DEAF OR HOH? _____ DEVICE NEEDED? _____

PRIMARY LANGUAGE: NEED INTERPRETER? ☐ YES ☐ NO LANGUAGE/DIALECT:

EMERGENCY CONTACT NAME	RELATION	PHONE #

SAFETY ISSUES: ☐ WEAPONS ☐ VIOLENCE TOWARD OTHERS ☐ OTHER HOME ENVIRONMENTAL RISK

☐ NONE ☐ SUICIDE RISK ☐ ANIMALS ☐ INFECTIOUS DISEASE?

INSURANCE INFORMATION:

MEDICARE? ☐ YES ☐ NO MEDICAID? ☐ YES ☐ NO THIRD PARTY? ☐ YES ☐ NO

Medicare #: ProviderOne ID#: I.D.#:

PRIMARY CARE PHYSICIAN: PHONE #: FAX #:

IS PCP ABLE/WILLING TO PRESCRIBE/MANAGE PSYCH MEDS: ☐ YES ☐ NO

ANOTHER HOME HEALTH AGENCY INVOLVED? ☐ YES ☐ NO AGENCY: _____ PHONE #: _____

REFERRAL INFORMATION:

MEDICAL DIAGNOSIS/PROBLEMS:

HOSPITALIZATIONS:

PSYCH MEDS:

MENTAL HEALTH ISSUES – REASON FOR REFERRAL:

**** SEND COMPLETED FORM TO:***

Behavioral Health
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