Estelle's Personal Care Services MHSS Referral Form

Today's Date: _____

Referral Source: _____

Referring Agency:_____ **Referral Source Phone**: _____

Reason for Referral: _____

Client Name: _____ **Gender**:_____

Client Address: _____ **Client Phone**: _____

DOB: _____ **Age**: _____ **Do you have Medicaid? Yes / No** (circle)

Medicaid Number: _____

Social Security #: _____ **Monthly Income**: _____

Criteria for Services: **DX**:_____ (**psychotic disorder, major depressive disorder – recurrent, or bipolar disorder I or II**)

The individual must have both of the following:

Psychiatric hospitalization; facility _____ **Psychiatric medications; list**: _____

Are you currently receiving MHSS? _____ **Agency**: _____

Are you a returning/past client? _____ **Are you currently in crisis intervention or crisis stabilization**? _____

Do you have specialized ambulation needs? _____

Are you currently hospitalized? _____ **Location**:_____ **Discharge Date**:_____

Do you receive case management from the CSB?_____ **Case Manager Name**_____

Case Manger Contact Number_____

Comments: _____

Please fax referral form to 757-299-1921
Please call our office at 757-620-1008 if you have any questions

Office Staff Only

Was the referral accepted?_____

If declined, where was s/he referred?_____

Reason declined? _____

Intake Coordinator Signature_____ Date_____