Redefining the Future NETWORK

Wellbeing Redefined. Life Reimagined.

Supported Employment Referral

Client Demographics			
Referral Date:			
Client First Name:		Client Last Name:	
Birthdate:		Age:	
Race:		Sex at Birth:	
Home Address:			
Phone Number:		Email Address:	
Medicare Number:			

Client History	
Has the participant been in active mental health treatment?	☐ Yes ☐ No
Treating therapist name and credentials:	
Therapist phone number:	
Name of psychiatrist:	
Psychiatrist phone number:	
Has medication been prescribed to support mental health:	
Are you receiving case management?	☐ Yes ☐ No
Is there a primary behavioral diagnosis:	☐ Yes ☐ No (If yes, please describe below.)
Primary behavioral diagnosis:	

Employment Goals
Please describe your employment goals and/or interest below:
Please describe previous work experience:

Risk Assessment	
Are there any risks for aggressive behavior, suicide, or homicide?	☐ Yes ☐ No
Is there a history of in-patient or at risk for in-patient hospitalizations?	☐ Yes ☐ No
Are you currently on conditional release, parole, or probation?	☐ Yes ☐ No