

**PEACEFUL MINDS HEALTH SERVICES RSA REFERRAL**

*Please let us know how you heard about PMHS*

*□ Website □ Yellow Pages □ Physician □ Hospital □ Previous Client □ Family Member □ Brochure □ Other*

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| Referral Source Information |
| Referral Source Title: |       |
| Referral Source name: |       |
| Agency Name: |       |
| Phone#: |       | Cell #       | Fax#       |
| Email: |       |
| Service Requested  |       |

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| Patient Demographics |
| Name |  Last  | First       |
| Alias Name |  Last       | First       |
| Date of Birth |       | Age     | SS#       | Gender       |
| Ethnicity |   | Primary Language:       |
| Marital Status | [ ] Single [ ]  Married [ ]  Divorced [ ] Separated [ ]  Widow [ ]  Partnered  |
| Veteran  | [ ] Yes [ ] No  |  If yes, what is the year of discharge?       |
| Current Address | *[ ]  check here if Homeless*  |       | Zip code       |
| Contact Numbers | Home:       | Cell:       | Best time to call:       |
| Email Address |       |
| Accommodations | [ ] TTY [ ]  Interpreter [ ]  Sign language [ ]  Ambulatory limitations [ ]  Other |

**If client is a minor please complete the following information:**

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| Parent Guardian Information  |
| Last:       | First       |
|  Address:       |
| Phone Number: Age SS#      Gender       | Work Phone:       |
| Primary Language:      | Email:       |

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| Health Insurance Information |
| Medical Assistance [ ]  Yes [ ]  No | Medicare [ ]  Yes [ ]  No | Other:       |
| Medical Assistance or ID # |       |
| Private Insurance: [ ]  Yes [ ]  No | Name      | Group # |
| ID #:  | Co-Pay:  | Deductible:  |

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| **Primary Medical Diagnosis**  |  |
| **Diagnosis**  | **ICD-10 CODE** | **Description**  |
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| Medication  |  |
| Name of Medication  | Dose | Frequency  | Route |
|       |       |       |        |
|       |       |       |         |
|       |       |       |         |
|       |       |       |         |

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| Emergency Contact Information |
| Name:       | Relationship:       |
| Address:       |
| Phone Number:       |
| Guardian Name if applicable:       | Phone:       |
| Does participant have a Mental Health Advanced Directive (MHAD) or Medicaid Advance Directive completed within 1 year [ ] Yes [ ] No |
| If participant/patient is involved in Waiver Program Please List Here: |

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| Other Agency/Program Involvement |
| Supports Planner/ Coordinator  |       | Phone:       |
| Service Coordinator |       | Phone:       |
| Community Treatment Team |       | Phone:        |
| Peer Specialist |       | Phone:        |
| Legal Involvement  |       | Phone:        |
| Housing Support |       | Phone:       |
| Has a referral been made to any housing programs [ ] Yes [ ] No If yes, date referral was made:      Explanation:       |

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| Current Outpatient Provider/Services/Supports |
| **CURRENT PROVIDER** | **PROVIDER AGENCY** | **CONTACT NAME** | **CONTACT PHONE NUMBER** |
| Outpatient Psychiatrist |       |       |       |
| Outpatient Therapist |       |       |       |
| Primary Care Physician |       |       |       |
| Medical Specialist |       |       |       |

**By signing this form, I attest all the statements I have made, including my answers to all questions are true and correct to the best of knowledge and belief. I agree to give the eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification for services. My signature authorizes the providing agency begin the service(s) requested**

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**Client or Caregiver Signature Date**

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**Agency Employee Signature Date**