

3704 S. Hanover St. | Suite 2F | Baltimore, MD 21225

**RSA REFERRAL**

Please let us know how you heard about PMHS:

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

|  |  |  |  |
| --- | --- | --- | --- |
| 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:**

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

|  |  |  |
| --- | --- | --- |
| 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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|  | |  |  |  |
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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: | |

|  |  |  |
| --- | --- | --- |
| 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: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 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**