CONVERSION HEALTH SYSTEM

"Transforming Lives One Person At A Time"

REFERRAL FORM

Patient Name: _____ Date: _____

Demographics

DOB: ____ / ____ / ____ Age: _____ Social Security Number __ __ __-__ __-__ __ __ __

Address: _____

_____

Home #: _____ Cell #: _____Work #: _____

Email: _____

Insurance Type/Carrier: _____ ID: _____

Policy Holder Name: _____ Contact #:_____

Gender: [ ] Male [ ] Female [ ] Transgender Primary Language: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Are you a U.S. citizen? [ ] Yes [ ] No If no, country of citizenship _____

Ethnicity: Hispanic or Latino [ ] Not Hispanic or Latino Unknown or not reported

Race (check those with which you identify):

[ ] American Indian or Alaska Native Asian [ ] Black or African-American

[ ] Native Hawaiian or Other Pacific Islander [ ] White

[ ] More than one race Unknown or not reported

Employment Status

Check all that apply: [ ] Child [ ] Student [ ] Disabled [ ] Retired [ ] Self Employed

[ ] Active Duty Military [ ] Employed Full-Time [ ] Employed Part-Time [ ] Not Employed

Do you have a high school diploma or GED? [ ] Yes [ ] No Highest Grade Completed: _____

Guardianship

Guardian Name: _____ Relationship: _____

Address: _____

_____

Home #: _____ Cell #: _____Work #: _____

Email: _____

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Data

Is the Department of Social Service or Child Protective Service Involved? [ ] Yes [ ] No

Has the patient been arrested in the past three (3) months? [ ] Yes [ ] No

Has the patient been discharged from an inpatient treatment center or crisis facility in the past 3 months?

[ ] Yes [ ] No If yes, date of admission_____ date of discharge _____

-Does the patient have difficulty seeing or hearing? [ ] Yes [ ] No Use an assistive device: _____

-Does the patient have difficulty concentrating, remembering, or making decisions independently? [ ] Yes [ ] No

- Does the patient have behavior issues? [ ] Yes [ ] No

-Does the patient have difficulty keeping a job or housing [ ] Yes [ ] No

- Does the patient have social issues? [ ] Yes [ ] No

-Does the patient have emotional instability? [ ] Yes [ ] No

-Does the patient have difficulties with shopping, running errands, making doctor's appointments? [ ] Yes [ ] No

Referral Source

Referring Agency: _____ Fax: _____

Referring Provider: _____ Title: _____

Phone #: _____ Email: _____

Is Referral Court Ordered? [ ] Yes [ ] No

Requested CHS Service:

- ❑ Psychiatric Rehabilitation Program (PRP)-Mental Health- Adult
- ❑ Psychiatric Rehabilitation Program (PRP)-Mental Health- Child
- ❑ Intensive Outpatient Treatment (IOP)
- ❑ Outpatient Treatment (OP) Substance Abuse
- ❑ Buprenorphine or Medication Assisted Treatment (MAT)-Substance Abuse
- ❑ Supported Employment
- ❑ Medical Cannabis

Patient's Primary Diagnosis: _____

Other Diagnosis: _____

_____

Psychiatric Medication(s):_____

Allergies: _____

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Why are PRP services needed and how will the client benefit from PRP?

_____

_____

_____

_____

_____

Emergency Contact: _____ Phone #:_____

Signature of Referring Provider: _____ Date: _____