

PANHANDLE MENTAL HEALTH CENTER
And Region 1 Behavioral Health Authority
ECS/COMMUNITY SUPPORT SERVICES
REFERRAL FORM

PLEASE FAX TO COMMUNITY SUPPORT SUPERVISOR @ 308-632-2326

<input type="checkbox"/> SCOTTSBLUFF 308-632-4412 Fax: 308-632-2326 <input type="checkbox"/> M/H <input type="checkbox"/> S/A <input type="checkbox"/> ECS	<input type="checkbox"/> ALLIANCE 308-762-2545 Fax: 308-762-2564 <input type="checkbox"/> M/H	<input type="checkbox"/> SIDNEY 308-254-2649 Fax: 308-254-1014 <input type="checkbox"/> M/H <input type="checkbox"/> S/A <input type="checkbox"/> ECS
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Date of Referral _____ Referred By: _____
 Name: _____ DOB: _____ SSN #: _____
 Address: _____ Phone #: _____ Type of Phone _____

Alternate Address/Phone #: _____
 Living Arrangements: Lives alone Lives with relative Lives with Non relatives
 Emergency Contact Person: _____
 Name of Guardian or Payee: _____
 Address/Phone # of legal Guardian: Same as client Other: _____

Number of EPC's in past year: _____ Number of times in Detox in past year: _____
 Number of ER visits for psychiatric/substance abuse in past year: _____ Reason: _____
 Homeless at present Yes **NO**

Legal Status:
 ___ Voluntary Voluntary per Guardian MHB Order Court Order Prisoner Probation other:

Risk Assessment:
Danger to Self: Low Medium High NA **Danger to Others:** Low Medium High NA
Explain: _____

History of suicide attempt or other violent behavior? Yes No **Explain:** _____

Receiving/Eligible for: SSI/Disability Social Security Medicaid Medicare VA Benefits
 Other: _____

Diagnosis: _____ **date of diagnosis:** _____
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: Global Assessment of Functioning Scale _____

Other needed Information: _____

Does the client own a PET Yes No **Pets must be controlled by the owner when the CS worker visits.**

Client Name: _____ SSN: _____

Please check all areas that need to be addressed through community support and number according to highest priority.

- _____ Case Management/Coordination of Multiple Services
- _____ Relapse Prevention/Crisis Management
- _____ Interpersonal Skills
- _____ Independent and Community Living Skills
- _____ Formal/Informal Support System
- _____ Medication Education/Management/Access
- _____ Mental Health Treatment
- _____ Substance Abuse Treatment
- _____ Gambling Treatment
- _____ Medical Dental Services
- _____ Income/Money Management
- _____ Housing
- _____ Vocational/Educational Skills
- _____ Legal Issues
- _____ Home Management Skills, Including Housekeeping
- _____ Personal Care/Hygiene
- _____ Nutrition/Meal Planning/Obtaining Food
- _____ Social Leisure Skills
- _____ Spiritual/Cultural Issues
- _____ Other

What services is consumer currently participating in: _____

Estimated length of time services will be needed: _____

Signature of Person Referring to Community Support /Date Phone

Agency, Facility or Address of Referring Person Phone

[Completed by Community Support Supervisor]

Date of Referral:		Reason Ineligible:
Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Age
Assigned to CSS Worker:		<input type="checkbox"/> Residence
Date Assigned:		<input type="checkbox"/> Diagnosis
Date of first contact:		<input type="checkbox"/> Safety Concerns
		<input type="checkbox"/> Concurrent higher level of care
		<input type="checkbox"/> Other

PLEASE FAX TO Bonnie Lockhart @ 308-632-2326

Supervisor Signature Date