# REFERRAL FORM – COMMUNITY MENTAL HEALTH

| Identifying Information | | | |
|---|---|---|---|
| NAME | CASE # | DOB | GENDER |
| ADDRESS | | | |

| Consumer Information | | | |
|---|---|---|---|
| ADDRESS | | | |
| CITY | STATE | ZIP | ALTERNATE PHONE |
| PRIMARY PHONE | COUNTY OF RESIDENCE | | |
| DATE OF BIRTH | MI CHILD ID# | MEDICAID IDENTIFIER | |

## Disability Designation

DEVELOPMENTAL DISABILITY
☐ YES ☐ NO

MENTAL ILLNESS
☐ YES ☐ NO

PRIMARY DESIGNATION
☐ MI ☐ DD

SUD
☐ No SUD
☐ Not Evaluated for SUD
☐ 1 or more SUD Dx Codes active or in partial remission (use within past year)
☐ Results from screening suggest SUD

INDIVIDUAL RECEIVED AN ASSESSMENT ONLY, AND WAS FOUND TO MEET NONE OF THE DISABILITIES LISTED ABOVE
☐ YES ☐ NO

| Court Appointed Guardian | |
|---|---|
| FIRST NAME | LAST NAME |
| ADDRESS | |
| PHONE NUMBER # 1 | PHONE NUMBER # 2 |
| TYPE OF GUARDIANSHIP | |
| DESCRIBE POWERS | |
| GUARDIAN'S RELATIONSHIP TO CONSUMER | |

| Additional Contact | | | |
|---|---|---|---|
| LAST NAME | FIRST NAME | PHONE NUMBER | ALT PHONE |
| ADDRESS | | | |
| RELATIONSHIP | | ☐ Do Not Contact | |

## Diagnosis

| | | ICD-9 | DSM-IV | DESCRIPTION | STATUS DATE | STATUS |
|---|---|---|---|---|---|---|
| **AXIS 1** | | | | | | |
| **AXIS II** | | | | | | |
| **AXIS III** | **No diagnoses exist in AXIS III** | | | | | |
| **AXIS IV** | ☐ Economic problems<br>☐ Problem accessing healthcare<br>☐ Educational problems<br>☐ Occupational problems<br>☐ Housing problems | | | ☐ Problems with primary support group<br>☐ Problems related to social environment<br>☐ Problem related to interaction with legal system<br>☐ Other psychosocial and environmental problems<br>☐ Behavioral/Personality issues | | |
| **AXIS V** | CURRENT GAF | | DATE | SIS SCORE | | DATE |

## Consumer's Needs/Concerns