

Community Care Behavioral Health Referral Form

Freehold Piscataway

Date of Referral _____

For office use only:

Intake

Date _____

Time _____

CLIENT INFORMATION:

Client's Name _____ Date of Birth _____

Client Address _____

Phone # _____ Social Security # _____

Medicaid # _____ HMO and ID # _____

Diagnosis _____

Reason for Referral _____

Guardian Maintained By Client Other _____

Copy of Guardianship Paper Yes No Requested Date: _____

CLIENT RESOURCES:

Referral Agency/Person _____

Phone # _____ Fax # _____

Residence Type and Contact _____ Phone # _____

Primary Physician _____ Phone # _____

Primary Psychiatrist (If not using program psychiatrist): _____

_____ Phone # _____

Other Case Workers (DDD, IOC) _____ Phone # _____

Other Case Workers (DDD, IOC) _____ Phone # _____

MEDICATION AND HISTORY:

Pharmacy _____ Location _____ Phone # _____ Fax # _____

Clozaril Yes No (Dosage _____ Date of Last Blood Work _____ Freq of Blood Work _____)

Injectable Yes No (Dosage _____ Date of Last Injection _____ Freq of Injection _____)

*****Please Attach Most Current Medication List (Include Dosage and Frequency)*****

Allergies _____

Medical Issues _____

History of Suicide Attempts Yes No Describe _____

Legal Involvement Yes No Describe _____

History of Violence Yes No Describe _____

Substance Use Yes No Drug of Choice _____ Date Last Used _____

Most Recent Hospitalization Location _____ Date _____

CCBH Intake Coordinator _____ Date _____

CCBH Psychiatrist _____ Date _____