For office use only:

Intake

Date_____

Time_____

Community Care Behavioral Health Referral Form

☐ Freehold ☐ Piscataway

Date of Referral_____

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:

Emergency Contact_____**Relationship to Client**_____**Phone #**_____

Referral Agency/Person_____ **Phone #** _____

Residence Type and Contact _____ **Phone #** _____

Primary Physician_____ **Phone #** _____ **Fax #**_____

Primary Psychiatrist (If not using program psychiatrist):

_____ **Phone #** _____

Transfer to CCBH Psychiatrist ☐ Yes ☐ No

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

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

MEDICATION AND HISTORY:

Pharmacy _____**City**_____ **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** _____