



Rochester Rehabilitation

MENTAL HEALTH SERVICES REFERRAL FORM

Continuing Day Tx-Older Adults ACHC / Satellite Clinic Partial Hospitalization Program Continuing Day Tx-Younger Adults Clinic

Date Referral Form Completed: _____

Please complete ALL information requested. Incomplete information may delay processing your referral.

Individual's Name _____ DOB _____ Age _____ SS # _____

Male Female Address _____ Apt. #: _____ Zip _____ Phone _____

Present living arrangements Alone Spouse Parents Residential Facility Institution Other Relatives Other Non-Relatives

Race: Caucasian African-American Hispanic Asian Other: _____

Primary Language: English Spanish Sign Other: _____

How did you hear about our Services? _____

Do you have a Family Member Significant Other currently receiving Mental Health Services at Rochester Rehabilitation?

INSURANCE INFORMATION (REQUIRED) Note: If Insurance requires preauthorization; patient will need to contact their primary care physician

Primary Medical Insurance Name _____ Number _____

Secondary Medical Insurance Name _____ Number _____

Name of subscriber _____ Relationship of subscriber to individual Self Spouse Dependent Other:

Medicaid spend down Yes No If yes, spend down amount \$ _____

Reason for Referral/Precipitating Event: _____

Current behaviors and psychiatric symptoms (check all that apply and explain below):

- Physically or verbally abusive
- Wandering
- Poor Judgment
- Sexual inappropriateness
- Dangerous to self or others
- Depression
- Bizarre Behavior
- Poor coping skills
- Confusion/Disorientation
- Paranoia
- Socially Withdrawn
- ETOH/Substance Abuse
- Non-compliant with medications
- Memory Loss
- Low Self Esteem
- Problems with Eating/Sleeping
- Ritualistic Behavior
- Anxiety/Agitation

Psychiatric Diagnosis (Current DSM IV) Axis I _____

Axis II _____

Axis III _____

Patient Health Team Members (name and phone)

Phone Number

PCP _____

Therapist _____

Case manager(ICM/SCM) _____

Residential contact _____

Care Coordinator _____

Other (i.e. AOT, Psychiatrist) _____

Emergency Contact Person _____

Address: _____

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Is the individual agreeable to the referral? Yes No Is the health care provider agreeable to this referral? Yes No

Extent of family involvement in individual's treatment (please describes degree of support, involvement, frequency of contact and identify family members by name and relationship to client).

Previous psychiatric hospitalizations or Outpatient Programs:

Adm/Disc Date	Facility/location	Adm/Disc Date	Facility/Location/Provider
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications, Dosage & Frequency Prescribed by: _____

Chronic Medical Condition(s): _____

Allergies to Medications/Foods: _____

Physical limitations/special needs Communication Mobility Diet Other: _____

Comments: _____

Will the individual require transportation assistance: No Yes If YES, what type: _____

Highest Education level completed: Grade School GED HS diploma Vocational School College (no degree)
 College degree Other: _____

Present or Previous Occupation _____

Please Attach the following additional information:

PLEASE MAIL / FAX REFERRAL FORM AND INFO TO:

- **Clinical Summary / Psychosocial History**
- **Current Physical Exam Report**
- **Copies of Insurance cards**

Intake Coordinator (MHS)
 Rochester Rehabilitation
 1000 Elmwood Avenue Rochester, NY 14620
 PH: (585) 271.2520 FAX: (585) 295.6070

Referring Individual (please print): _____ Phone: _____

Referring Agency: _____

Referring NPI Number: _____

Contact for Appointment: _____

*****OFFICE USE ONLY*****

Date Referral rec'd: _____ Account/Case Number: _____

Date/Time of Initial Appointment _____ / _____