Rochester Rehabilitation

MENTAL HEALTH REFERRAL FORM

Date Completed: _____

❑ MH CLINIC ❑ VENTURES PROS
❑ HCBS

INDIVIDUAL INFORMATION					
Name:		DOB:		To which gender do you most identify? ❑ Male ❑ Female ❑ _____	
Address: _____		Phone: _____(H) _____ (C) Email:			
Ethnicity:	❑ Caucasian	❑ African American	❑ Hispanic	❑ Asian	❑ Other (specify)
Primary Language:	❑ English	❑ Spanish	❑ ASL	❑ Other (specify)	
Marital Status:		Are you a Veteran?			
Highest Level of Education Completed:	❑ High School	❑ GED	❑ Some College	❑ Degree	
Religion:					
Current Legal Status:	❑ None	❑ Parole	❑ Probation	❑ Pending	
Living Arrangement:					
Emergency Contact:		Relationship:		Phone:	
Do you have a family member or significant other receiving mental health services at Rochester Rehabilitation? ❑ Yes ❑ No					

INSURANCE INFORMATION			
Social Security Number:			
Medicaid Number:		County of Responsibility:	
Medicaid Option Plan: ❑ Yes ❑ No	If Yes: ❑ Blue Choice Option ❑ MVP ❑ Fidelis		
Medicare Number:		❑ Medicare Part A	❑ Medicare Part B
Medicaid Part D Number:		Provider:	
Other Insurance Provider:		Other Provider Number:	
Are you enrolled in any Medicaid Waiver Program? ❑ Yes ❑ No If Yes, provide contact information:			
Employment Status:		Occupation:	
Do you have a Medicaid spend-down: ❑ Yes ❑ No If Yes, spend-down amount: $			
Do you participate in Medicaid buy-in? ❑ Yes ❑ No			

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CURRENT SERVICE PROVIDERS			
	Name/Address	Phone	Fax
Primary Care Medical Provider			
Therapist			
Psychiatrist			
Case Manager			
Residential Contact			
Other Psychiatry Services			

PERSONAL GOAL INFORMATION

What are your life goals? _____

What barriers to those goals are you working to overcome? _____

What symptoms do you experience (check all that apply):

- ❑ Dangerous to self or others
- ❑ History of suicide, danger to self
- ❑ Self harm (self-injurious behaviors)
- ❑ Homicidal – danger to others
- ❑ Ritualistic behavior
- ❑ Depression/Mania
- ❑ Anxiety/Agitation
- ❑ Paranoia
- ❑ Hallucinations
- ❑ Severe mood swings
- ❑ Confusion/Disorientation
- ❑ Poor judgment/impulsivity
- ❑ Memory loss
- ❑ Socially withdrawn
- ❑ Sexual inappropriateness
- ❑ Non-compliant with medications
- ❑ Problems with eating
- ❑ Problems with sleeping
- ❑ Racing thoughts
- ❑ Other: _____

_____

Describe your ability to participate, interact, and accept responsibility in group situations:

_____

PSYCHIATRIC DIAGNOSIS

Primary Diagnosis: _____

Previous psychiatric hospitalizations: Admission/Discharge dates:

_____ _____

_____ _____

Previous Outpatient programs: Admission/Discharge dates:

_____ _____

_____ _____

Current Medications: _____

Chronic Medical Conditions: _____

Special Needs: Allergies (Foods or Medications):

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DRUG AND ALCOHOL SCREENING	
Please give a brief overview of your experience with drugs and alcohol: _____	
Age of first use: _____	Substance(s) used: _____
Date of last use:	Substance(s) used:
Have you ever received treatment for addiction and if so, please give provider and dates of service: _____	
Are you currently receiving substance abuse treatment or involved in self-help groups? If yes, please specify: _____	

REQUIRED SERVICES	
What mental health services might be helpful to you? Please check all that apply:	
❑	MH Center Only: individual counseling and psychotherapy, group therapy, and medication evaluation/consultation for adults that experience barriers to functioning in their everyday lives.
❑	PROS Continued Recovery Support (CRS): classes, groups, and skills development opportunities to improve self care, life management, community living, social and work readiness skills.
❑	PROS Clinical Treatment: working with a prescriber, nurse, and therapist on medication and symptom management. (Must receive other PROS services as well).
❑	PROS Intensive Rehabilitation (IR): short term service to work intensely on a rehabilitation goal such as achieving a life role or intensive symptom management to avoid losing a life role.
❑	PROS Ongoing Rehabilitation Support (ORS): vocational support for individual currently employed at least 10 hours per week.
❑	HCBS (Home & Community Based Services) – ATTACH PLAN OF ACTION ❑ Individual Employment Services ❑ Empowerment services | Peer Support

Please mail or fax the information requested below along with the Referral Form to:

Mental Health Center Intake Coordinator
Rochester Rehabilitation
1000 Elmwood Ave| Rochester NY 14620
Phone: 585.271.2520 x1594 | Fax: 585.286-9236

OR

Ventures PROS Intake Coordinator
Rochester Rehabilitation – Ventures PROS
975 Elmwood Ave | Rochester, NY 14620
Phone: 585-256-3430 x1132 | Fax: 585-286-9226

Referring Individual (please print): _____ Signature: _____

Referring Agency: _____

Phone: _____ Email: _____

Licensed Practitioner's Signature: _____

Please include:
- ❑ Clinical summary or current psychosocial history
- ❑ Current treatment plan (if applicable)
- ❑ Copies of insurance cards
- ❑ Current medication log (if applicable)
- ❑ Other psychiatric services client receives (for example, outpatient group)