Rivers Edge Behavioral Health Services, LLC

Referral Form

Section 1: Program Information

Which program/level of care is the current referral intended for?

Residential:

___ Bella's House

Section 2: Client Information

First & Last Name	
Date of Birth	
Gender at Birth	
Current Identified Gender	
Home Address (Mailing & Street)	
Home County	
Phone Number (with area code)	
Insurance Company Name	
Insurance Policy Number	
Race/Ethnicity	
Marital Status	
Are you Employed?	
Emergency Contact First & Last Name	

Emergency Contact Phone Number (with area code)	
Emergency Contact Relationship	

Can we state that we are calling from Rivers Edge Behavioral Health Services when calling the phone number listed above?

_____ Yes
_____ No

Do you have a need for language/interpretation services?

_____ Yes - please specify_____
_____ No

Section 3: Referring Entity Information

Is this a self-referral?

_____ Yes
_____ No – please complete the section below

Entity Name Please provide biopsychosocial, TB test results or other test results, any labs and physical within the past year	
Referral Source Contact – First & Last Name	
Referral Source Contact – Phone Number (with area code)	
Referral Source Address (Street. City, State, Zip)	
Referral Source Email Address & Fax Number	
Is this mandated treatment (court, probation)? _____ Yes _____ No	
Is the client currently receiving additional services from other agencies? _____ Yes – Please specify (description of services, contact name & phone number, duration of services) _____ No	

Section 4: History

Previous Treatment History Please include dates, drug of choice, treatment Facility/level of care (detox, mental health, inpatient)	
Individual's drug of choice Please include: • Name of Drug • Date of Last Use • Frequency of Use • Any other relevant information	
Substance Use Diagnosis (DSM5) _____ Yes – please specify _____ No	
Mental Health Diagnosis (DSM5) _____ Yes – please specify _____ No	
Any history of IV drug use? ____ Yes – please indicate date last used _____ No	
Any chance of being pregnant? _____ Yes _____ No	
Does this individual have a primary care provider? ____ Yes – please provide name and phone number ____ No	
Does this individual have any chronic or acute medical conditions? ____ Yes – please specify ____ No	
Is client currently on probation/parole? ____ Yes – Please include name, contact number and reason ____ No	

Is client currently involved with Department of Child & Family Services? ____ Yes – Please include contact name & phone number _____ No	
Has client been arrested in the past 30 days? _____ Yes – for what reason and any pending court dates _____ No	
Has client ever committed acts of arson? _____ Yes _____ No	
Has client ever been involved with, arrested or charged with any violent crime? _____ Yes – list arrests or charges _____ No	
Is client having any thoughts about ending their life or wanting to die? _____ Yes _____ No	
Is client having any thoughts about wanting to hurt or Harm someone else? _____ Yes _____ No	
Is client currently taking any medications? _____ Yes – please specify names & current prescriber _____ No	
Is client currently using MAT? _____ Yes – see below and include prescriber's name _____ No _____methadone _____ naltrexone ____ suboxone _____ sublocade injection ____ subutex _____ vivitrol	

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Narration: Please provide additional information that may be helpful to the treatment team assessing this client.

Hospitals detox facilities and other treatment programs
Please include the following records with the referral:

1. History & Physical
2. Lab results within the past year
3. TB tests & other tests
4. Medication list
5. Nursing assessment
6. Biopsychosocial assessment
7. Psychiatric evaluation
8. Other pertinent information