MULTI-SERVICE REFERRAL FORM

Please note that any referral that is received by Sound Community Services that is not accompanied by a signed release of information as well as a signed referral form will not be accepted.

GUIDELINES FOR USE:

1. Complete all information (Social Security number must be noted on form).
2. Complete using information from current or most recent treatment provider.
3. Describe services currently received, service needs/current status and reason for referral.
4. List applicable insurance policy numbers.
5. List monthly amount received from applicable financial sources.
6. Attach a current list of medications, known allergies, and treatment provider.
7. Next of kin or emergency contact information, including individuals considered by person served to be natural supports. If person is conserved, attach a copy of the conservatorship decree.
8. Provide employment information including current status and goals.
9. Histories of inpatient hospitalizations, including reason, approximate dates, and lengths of stay.
10. Describe known risks, stressors, precipitators to hospitalization, and interventions successful in the past.
11. Indicate any requested service(s)/program(s) from SCSI with a check mark.
12. Indicate agency/provider to receive referral. Indicate any requested service(s)/program(s)
13. Referral not valid unless accompanied by signed Release of Information.
14. Please attach W-10, discharge summary, and/or most recent assessment, if applicable.
15. Indicate preferred initial contact for referral/assessment.

Provide printed name and signature of person filling out referral form, agency name and phone number in the space provided. Please fax to 860-333-6026, thank you.

SCSI OFFICE ONLY Received by: _____

Date: _____

A. DEMOGRAPHICS **Date of Referral: _____**

Name: _____ DOB: _____ Age: _____ SS#: _____

Physical Address: _____ City: _____ State: _____ Zip:_____

(if different than physical address)

Mailing Address: _____ City: _____ State: _____ Zip:_____

Phone: Primary Phone #_____ Education Level: _____ Veteran: □Yes □No

Race: (Check One) □Amer. Indian □Asian □Black □Pacific-Islander □White □Other_____

Gender: □Male □ Female Primary Language: _____

B. DIAGNOSIS (DSM 5 Code)

PRIORITY	DIAGNOSIS

PSYCHOSOCIAL & CONTEXTUAL FACTORS

(GAF) _____

Stage of Treatment: [ ] Pre-engagement [ ] Engagement [ ] Early Persuasion [ ] Late Persuasion [ ] Early Active

[ ] Late Active [ ] Relapse Prevention [ ] In Remission / Recovery [ ] Not Applicable

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C. CURRENT SITUATION / REASON FOR REFERRAL (Include current services received; natural and community supports; risk management and/or safety concerns; presenting needs, strengths, abilities, goals; areas requiring skill-teaching)

_____

_____

_____

_____

_____

_____

D. MEDICAL COVERAGE

Medicaid (Title XIX#):_____ Medicare #: _____ Other / #: _____

Private Insurance Carrier & Policy #: _____Group #:_____

E. MONTHLY INCOME

Employment $: _____ SSD $:_____ SSI $: _____ State Supplement $: _____

Other $/and source: _____

F. MEDICATIONS & DOSAGES Known Allergies: _____

If referral is requesting medication services, please attach the last 6 months of records if applicable

Prescribing Physician / APRN: _____ Agency: _____ Phone: _____

G. EMERGENCY CONTACT PERSON

Name: _____ Relation to Person Served: _____

Address: _____ Phone: _____

Other Natural Supports: _____

H. HISTORY OF PSYCHIATRIC / SUBSTANCE ABUSE HOSPITALIZATIONS OR TREATMENT PROGRAMS

(Include PHP, IOP, Detox, Residential, Inpatient and/or Outpatient Treatment)

Facility	Dates

I. HISTORY OF RISK FACTORS (Check all that apply)

_____History of alcohol / drug use

_____History of arson

_____Sexually assaultive behavior

_____Assaults or threats of assault in hospital or community

_____Access to weapons

_____Returning to dangerous environment

_____Suicidal behavior/threats/gestures/attempts

_____Non-compliant with orders re: serious medical condition

Comment on checked items:

_____
_____
_____
_____
_____

Known stressors / Indicators to decompensation / Recommended Interventions:

_____
_____
_____
_____
_____

J. IF REQUESTING SERVICES FROM SOUND COMMUNITY SERVICES (Check all that apply):

_____Medication Management _____Individual Therapy _____ Outpatient Group

_____ Intensive Outpatient Program (New London)

_____ Intensive Outpatient Program (Norwich)

_____Bent Crandall Dual-Diagnosis Program _____Supervised Apartment Program

_____ Community Support Program (Case Management) _____Employment Services

_____Social Rehabilitation/Oasis _____AXS Center (Young Adults)

M. CONTACT INFORMATION

Name of Contact Person for Referral:_____Signature:_____

Referring Agency Name: _____ Phone/Fax #: _____

Referring Contact Signature:_____

Signature of Person Served: _____

Preferred Contact to Initiate Services:_____

☐Please contact referral source

☐Please contact Person Served/Client

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Please attach W-10, discharge summary, and/or most recent assessment, if applicable.