CCFL REFERRAL INSTRUCTIONS

Please:

1. Complete all spaces on the referral form. Note if an area is not applicable.

2. Attach all requested reports/summaries.

3. Enclose verification of income if the consumer does not currently received MA.

4. If individual has a legal guardian, copies of court document needs to be included with referral.

5. Must be signed by a licensed professional with credentials.

6. Please see attachment 1 for the approved Priority Population Diagnoses for Adults.

All referrals are reviewed for completeness. If not complete, the referral is not processed and is returned for the additional information.

CHARLES COUNTY FREEDOM LANDING, INC.
REFERRAL

Recommended Services: On Site Support (day program) ___ Vocational Services____ Off Site Support (Supported Housing)___
Residential (General Support)___ Residential (Intensive Support) ___

I. DEMOGRAPHICS

Name:________________________________ Social Security #:______________________

Marital Status: __________ Date of Birth:________ Sex:________ Phone#:______________

Court appointed guardian:____
Name Telephone #

Applicant live with: Spouse____ Child____ Parent(s)____ Alone____ Other (specify)____________

Residential address:____

Directions to residence:____

____

Children and ages:____

Last completed grade/level of education:______________ Occupation:_________________

II. FISCAL INFORATION

Does applicant have:	Yes		No	Pending
Medical Assistance	___	#_______________________	___	___
Medicare	___	#_______________________	___	___
SSDI/SSI	___	Amt/mo.__________________	___	___
Earned Income	___	Average mo. Income__________	___	
Insurance	___	Type____________________	___	
Representative Payee	___	Name &Tel #:_______________	___	

III. REFERRAL INFORMATION

Person making referral:_______________________________ Phone:______________

Name and address of agency:____

Emergency contact person:______________________________ Phone:______________

Therapist:____ Phone:______________

Case Manager:____ Phone:______________

Medical Doctor:_______________________________________ Phone:______________

Psychiatrist:____ Phone:______________

IV. PSYCHIATRIC HISTORY

Describe reason for referral and any evident precipitants and symptoms:____________________

____

____

Current diagnosis and codes:

Axis I: ____________________ Axis II: ____________________

Axis III: ____________________ Axis IV: ____________________

Axis V: ____________________ Date of assignment:____________________

Please list current psychotropic (a) medications, (b) dosages, (c) frequency to include date of last injection:

(a)	(b)	(c)

Applicant's past hospitalizations and outpatient treatment dates, begin with most recent:__________

____

____

____

Is there a history of suicidal ideation? Yes_____ No_____ If yes, please describe: ____________

____

Is there history of assaultive/aggressive behavior? Yes_____ No_____ If yes, please describe:__________

____

____

What other information may be helpful in crisis prevention and stabilization for applicant? __________

____

____

V. MEDICAL HISTORY

Date of last physical exam: _______________ Please list any somatic medications below:

(b)	(b)	(c)

List applicant's past or current medical conditions/diseases and treatment.

____

____

Does applicant have any known ALLERGIES? ___ No ___Yes, to:________________________

Does applicant have any special dietary considerations? ___ No ___ Yes, type:________________

Does applicant have any medical handicaps or disabilities? ___No ___ Yes, type:________________

Does applicant have any neurologic disorder? ___ No ___ Yes, type:________________________

Has applicant been diagnosed with any communicable disease? ___ No ___ Yes, type:____________

VI. SUBSTANCE ABUSE HISTORY

Does applicant have a history or substance abuse? ___ No ___ Yes Or current substance abuse? ___ No ___ Yes

If yes, frequency of use:____

VII. LEGAL HISTORY

Does applicant have any current and/or pending charges? ___No ___ Yes

Charges and court dates: ____

Attorney:____ Phone: ________________

Prior legal charges, date, state, disposition: ________________________________

____

The above named individual is being referred for assessment and rehabilitation services.

VIII. CERTIFICATION BY

PHYSICIAN:____ Phone:________________

Signature Date

Submit the following information/reports WITH ORIGINAL REFERRAL to prevent delays:

____ **Psychiatric** ____ **Psychological** ____**Treatment Plan and Progress Notes**

____**Psychosocial** ____**Physical Exam** ____**Conditional Release**

Signature of person completing referral:________________________ Date:____________

Relationship to applicant:____

I agree to release this information to determine if Freedom Landing's rehabilitation services will benefit me.

Signature of applicant:____ Date:____________

IX. ELIGIBILITY CRITERIA

____ Meets eligibility ____ Does not meet eligibility