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:_____