B R I D G E W A Y REFERRAL F O R M

Complete this Form and Fax To:	➢ **Bridgeway Supportive Housing Union**
	908-249-4106

REFERRAL SOURCE INFORMATION

Today's Date:		**Referring Agency is: (check if applicable)**			
Referring Person's Name:			**STATE**		**PH/PC**
Referring Agency Name:			**VNA**		**STCF**
Phone #:			**ICMS**		**IPU**
Fax #:			**PACT**		**ER**

DEMOGRAPHIC INFORMATION

Client Name:		**SS#:**	**Client phone#:**
Emergency Contact:		**Client Mobile Phone#:**	
		Medicare#:	**PAAD#:**
		Medicaid#:	**Smoker:____ Non:_____**
Client Address:		**DSV Codes:** **Axis I:** **DSMV Codes:** **Axis II:**	

Phone #:		**Source and amount of monthly income**	$_____SSI $_____VA $_____Salary $_____SSD $_____Unemploy $_____Child Support $_____Alimony $_____Welfare $_____Pension $_____None $_____Food stamps
Date of Birth:			
Gender:		**Marital status**	
Ethnicity:			

	Children: Age(s)/Gender:
Criminal Record/ Current Legal Status:	

SERVICE NEEDS / ELIGIBILITY CRITERIA Check all that apply in desired program.
Must be Union County resident and have a primary diagnosis of a major psychiatric disorder.

Homeless Outreach:	___ Homeless ___ Single Adult ___ Referral and linkage
Partial Care:	___ Employment Services ___ Independent Living Skills ___ MICA Services ___ Stabilization / Structure ___ Mental Health Education ___ Socialization ___Supportive Counseling

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SERVICE NEEDS / ELIGIBILITY CRITERIA Check all that apply in desired program.
Must be Union County resident and have a primary diagnosis of a major psychiatric disorder.

Supportive Housing	**___ Consumer wants permanent, affordable housing ____Currently in own home.** **___ Consumer wants to live independently with supports.** **____Consumer is currently on Non-CEPP status** **___Consumer has significant co-occurring issues, which may include substance abuse, medical issues,etc.**
PACT Team Services:	_x_ Serious & persistent mental illness of at least 12 months duration ___ Demonstrated lack of benefit from refusal to participate in intensive ambulatory or residential mental health services for a duration of at least six months. **Hospitalization history within past 18 months (must meet one of the following):** ___ Two or more State Hospitalizations ___ One State Hospitalization with one or more other psychiatric hospitalizations ___ One State Hospitalization with multiple screening center episodes ___Two or more STCF and/or County Hospital admissions ___One STCF or County Hospital Admission with one or more other psychiatric hospital admissions/or multiple screening center episodes ___Two or more involuntary psychiatric hospital admissions at private psychiatric hospital
IPU Dates for past 18 months:	

PRESENTING PROBLEMS (Check all that apply)

____Alcohol Abuse	**___ Drug Abuse**	**___ Organic Mental Disorder**
___ Anxiety	**___ Eating Disorder**	**___ Physical Neglect**
___ Assaultive Behav./Threat	**___ Economic Stress**	**___ Runaway Behavior**
___ Bizarre Behavior	**___ Fire Setting / Ideation**	**___ Sexual Abuse/ Rape Victim**
___ Daily Living Problems	**___ Homicidal Behavior / Threat**	**___ Sexual Abuser**
___ Depression/ Mood Disorder	**___ Legal / Justice Involvement**	**___ Social / Interpersonal**
	___ Marital/Family Problems	**___ Suicide Attempt**
___ Destructive to Property	**___ Medical / Somatic Concerns**	**___ Suicide Threat**
___ Developmental Disability	**___ No Social Support Resources**	**___ Thought Disorder**
		___ Other:

PRESENT COMMUNITY TREATMENT PLAN (for Partial Care and/or Homeless Outreach referrals *only*)

Psychiatrist Name:	**Service Provider Name:**
Phone:	**Phone:**
Address:	**Address:**
Next Appointment:	**Next Appointment:**

CURRENT MEDICATION (for all referrals)

Medication	Dosage	Frequency

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PSYCHIATRIC BACKGROUND INFORMATION To be completed only if no psychiatric or medical records accompany the referral
Psychiatric History:
Precipitating Factors for most recent Hospitalization:
Physical/ Medical conditions:
Substance Abuse History/Treatment:
Comments: (Please include a brief description of any significant impression or other relevant concerns)

FOR INTERNAL USE ONLY:

ACCEPTED: _____ DATE STARTED: _____
NOT ACCEPTED:_____
REASON FOR NOT ACCEPTANCE:
_____ Does not meet eligibility criteria _____Lost _____Substance Abuse only
_____ Refused program _____ Long term Hospitalization
_____ Other:_____
REFERRED TO:_____

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