Bridgeway
Behavioral Health Services

PC / HO / SH / PACT / RIST GENERAL REFERRAL FORM

The latest edition of this form may be found at https://www.bridgewaybhs.org/pubs/form.referral.general.pdf

INSTRUCTIONS

This Referral Form is a Fillable PDF. Download and save this form to retain data.
Fax the completed form to the appropriate program's fax number listed on the bottom of page 4 of this form.

REFERRAL SOURCE INFORMATION

Today's Date: ______________________
Name of Referrer: ______________________
Name of Referring Agency: ______________________
Agency Phone: ______________________
Agency Fax: ______________________

Referring Agency is: (check, if applicable)

- ☐ STATE
- ☐ PH/PC
- ☐ VNA
- ☐ STCF
- ☐ ICMS
- ☐ IPU
- ☐ PACT
- ☐ ER

PERSON SERVED PERSONAL AND DEMOGRAPHIC INFORMATION

Name of Person Served: ______________________
Street Address: ______________________
City: ______________________
State: ______ Zip: __________
Email Address: ______________________

SSN: ______________
Date of Birth: ______________
Home Phone: ______________
Cell Phone: ______________

Gender: ☐ Male ☐ Female
Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ *(other)* _____ / _____
Primary Spoken Language: ☐ English ☐ Spanish ☐ *(other)* __________
Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ White ☐ *(other)* __________
Marital Status: ☐ Single (never married) ☐ Married (or in a Domestic Partnership) ☐ Widowed ☐ Divorced ☐ Separated

Gender/Age of Children: ______________________
Religious Preference: ______________________
Citizen/Immigration Status: ______________________
Known Allergies: ______________________

Emergency Contact Name: ______________________
E.C. Cell Phone: ______________________
Street Address: ______________________
City: ______________________
State: ______ Zip: __________

Criminal Record / Legal Status:
____
____

Date of IPU Admission
____

DSM V and ICD Codes:
____
____

BENEFIT AND INSURANCE INFORMATION

Medicaid # ________ Medicare # ________ PAAD # ________ Private Ins# ________
SSI $ ________ SSD $ ________ Welfare $ ________ Salary $ ________
Pension / VA $ ________ Other $ ________ None ________ Unknown ________

Name of Payee: ______________________
Street, City, State, Zip: ______________________
Payee Phone: ______________________

Bridgeway
Behavioral Health Services

REFERRAL FOR:

PROGRAM-SPECIFIC INFORMATION* (Indicate all that apply in desired program)

*Must be a resident of the county for which you are applying and have a primary diagnosis of a major psychiatric disorder.

Partial Care:

- ☐ Employment Services
- ☐ Independent Living Skills
- ☐ Socialization
- ☐ MICA Services
- ☐ Stabilization / Structure
- ☐ Mental Health Education
- ☐ Supportive Counseling

Homeless Outreach:

- ☐ Homeless
- ☐ Single Adult
- ☐ Referral and Linkage
- ☐ At Risk of Homelessness
- ☐ Parent with Children

Supportive Housing:

- ☐ Individual wants permanent affordable housing.
- ☐ Individual wants to live independently with supports.
- ☐ Individual is living in a residential program and is ready to graduate to independent living.
- ☐ Individual is capable of taking care of some basic living skills but needs some support in some areas.
- ☐ Individual has some insight into his/her mental illness and is motivated to work on independent living goals.

PACT Team Services:

- ☐ Serious & persistent mental illness of at least 12 months in 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 and Names of hospitals for past 18 months (must complete for PACT admission):

____

____

PRESENTING PROBLEMS (Check all that apply)

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

Bridgeway
Behavioral Health Services

REFERRAL FOR: ______

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

PACT and Supportive Housing referrals may skip this section and proceed to the Current Medication section.

Psychiatrist Name: ______
Phone: ______
Street Address: ______
City: ______
State: ____ Zip: ______
Next Appointment: ______

Service Provider Name: ______
Phone: ______
Street Address: ______
City: ______
State: ____ Zip: ______
Next Appointment: ______

Medical Treatment Plan:

______

______

______

CURRENT MEDICATIONS (for all referrals)

Medication:	Dosage:	Frequency:

PSYCHIATRIC BACKGROUND INFORMATION

Complete this section ONLY IF no psychiatric or medical records accompany the referral.

Psychiatric History:

______

______

______

______

______

Precipitating Factors for most recent Hospitalization:

______

______

______

______

______

Bridgeway
Behavioral Health Services

REFERRAL FOR: ____________________

PSYCHIATRIC BACKGROUND INFORMATION (Continued)

Physical / Medical Conditions: ***(Please include date of last physical and fax documentation)***

____
____
____
____
____

Substance Abuse History / Treatment:

____
____
____
____
____

Comments: ***(Please include a brief description of any other relevant concerns)***

____
____
____
____
____

END OF REFERRAL FORM

Please fax this (and any specified attachments) to the appropriate County/Program's fax number listed below.

Program	Fax	Program	Fax	Program	Fax
Union PACT 1	(973) 860-5147	Passaic PACT 7	(973) 638-1126	Somerset/Warren/Hunterdon RIST 3	(908) 894-5309
Union PACT 2	(908) 248-0879	Passaic PACT 8	(973) 638-1119	Essex/Hudson RIST 5	(973) 707-2963
Union PACT 3	(973) 860-5515	Bergen PACT 9	(908) 248-9779	Homeless Outreach PATH Union	(973) 860-5166
Hunterdon/Warren PACT 4	(908) 835-8650	Essex PACT 10-13	(973) 860-5127	Supportive Housing Hunterdon	(908) 894-5309
Hudson PACT 5	(908) 248-9752	Middlesex RIST 1	(732) 771-2306	Supportive Housing / ISH Union	(973) 860-5166
Somerset PACT 6	(908) 595-1921	Middlesex RIST 2	(732) 771-2306		

FOR INTERNAL USE ONLY

☐ **ACCEPTED** **DATE STARTED:** ____________

☐ **NOT ACCEPTED**

REASON FOR DENIED ACCEPTANCE:

☐ Does not meet eligibility criteria
☐ Refused program
☐ Other: ____________________
☐ Lost
☐ Substance Abuse only
☐ Long term Hospitalization

☐ **REFERRED TO:** ______________________________