Bridgeway Behavioral Health Services
93 Stickles Pond Road
Newton, NJ 07860

Fax # : 973-383-8676
Phone #: 973-383-8670

REFERRAL FORM
COMMUNITY SUPPORT TEAM, SUSSEX

Referral Date: _____ Referred By (Name/Agency):_____

Name: _____ D.O.B. : _____
Address:_____ Social Security #:_____
_____ Cell Phone #:_____
Home Phone #: _____
Referring Contact Person:_____ Phone #: _____

Reason for referral?_____
_____
Services Requested:

❑ **Case Management**: ❑ **ICMS**: Recently discharged from state/county/voluntary psychiatric hospital and needs assistance to link to community services.

or

❑ **PATH**: Homeless or at risk of homelessness and diagnosed with a psychiatric illness; in need of assistance to secure housing and other services

or

❑ **SUPPORTED HOUSING**: Involved with mental health treatment and in need of additional support to maintain housing; linkages to services.

❑ **Partial Care**: 3 to 5 day programming. Illness management and skill development.

❑ **Supported Employment**: Support to choose, get, keep and leave competitive employment.

Comments: _____
_____

Income Source: _____
Insurance: _____
Medicaid #: _____ Medicare #: _____
Other: _____ ID #:_____

RECORDS MUST BE INCLUDED WITH REFERRAL
(i.e., Intake Assessment, Treatment Plan, Psychiatric Evaluation, Discharge Summary)
Mail or fax to the attention of *Access Coordinator*

Diagnoses/Codes

Psychiatric:_____

_____

Medical:_____

_____

Current Medications (dosage & frequency):_____

_____

_____

Treatment

Current Psychiatrist/APN:_____Phone#:_____ Therapist:_____

Community Supports:_____Phone #:_____

_____

Psychiatric Hospitalizations (includes dates): _____

_____

Medical Issues:_____

Alcohol or Substance Abuse: _____Yes _____ No Treatment Hx:_____

History of assault/violence:_____

Legal Involvement: _____

History of suicidality: _____

Family involvement: _____

For Bridgeway Use Only:

Identified Service Requests:

Date Received:_____ Intake Engagement Specialist:_____

Person Contacted: ____ Yes ____ No Dates_____ _____

Intake Date & Time:_____ Service: ICMS PATH SH PC SE

Immediate Needs _____

_____

Disposition/follow –up /plan for immediate needs_____

_____

Signature _____

Does not meet criteria for services (Circle all that apply) ICMS PATH PC OPAL SE

Follow up/referrals

_____

_____

Signature_____ Reviewed by (signature):_____

Title:_____