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: _____ SSN: _____
Street Address: _____ Date of Birth: _____
City: _____ Home Phone: _____
State: _____ Zip: _____ Cell Phone: _____
Email Address: _____

Gender: ☐ Male ☐ Female

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ *(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: _____

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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: _____

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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:

_____
_____
_____
_____
_____

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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.

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:** _____