PATHWAYS

REFERRAL FOR SERVICES

Recommended services:

Community Support	☐	Housing w/ Varied Support*	☐	Housing w/ Intensive Support*	☐
JDP Vocational Services	☐	On-Site Support (Day program)	☐	IHIP-A** TAY Program	☐
Brain Injury Recovery	☐	Evidence-Based Supported Employment	☐	Career Assessment	☐

I. DEMOGRAPHICS

Name:_____ SSN:_____

DOB:_____ Sex:_____ Applicant lives with: ☐ spouse ☐ child ☐ parent(s) ☐ alone ☐ other_____

Address:_____

Phone: _____

Directions to Residence:_____

_____

Marital Status:_____ Children & Ages:_____

Last completed grade/level of education:_____ Occupation:_____

II. FISCAL INFORMATION

Does applicant have:	Yes	No	Pending			
Medical Assistance	☐	☐	☐	Number_____	expiration_____	
Medicare	☐	☐	☐	Number_____	expiration_____	
SSDI/SSI	☐	☐	☐	Amount_____		
Earned Income	☐	☐		Average Monthly Income_____		
Food Stamps	☐	☐		Amount_____		
Insurance	☐	☐		Type_____	Company_____	
Other	☐	☐		Amount_____		
Representative Payee	☐	☐		Name_____	Phone_____	

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:_____

*Requires CSA Approval **In-Home Intervention Program for Adults (requires CSA Approval)

IV. PSYCHIATRIC HISTORY

Reason for Referral:

Describe applicant's current situation:

Applicant's goals/objectives:

Current diagnosis and codes and date of GAF assignment:
Axis I_____ Axis II_____
Axis III_____ Axis IV_____
Axis V: GAF_____ Date of Assignment_____
Applicant's past hospitalizations and dates (begin with most recent):

Outpatient treatment and dates:

Is applicant currently suicidal? ☐ Yes ☐ No Does applicant have a history of suicidal ideation and/or behavior? ☐ Yes ☐ No
Please describe:

Does the applicant currently display assaultive/aggressive behavior? ☐ Yes ☐ No
Is there a 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

List past or current medical conditions/diseases of applicant and treatment:

MEDICAL HISTORY (continued)

Does applicant have any:	No	Yes	
Allergies	☐	☐	To:_____
Special Dietary Considerations	☐	☐*	Type_____
Medical Handicaps/Disabilities	☐	☐*	Type_____
Neurologic Disorder	☐	☐*	Type_____

Has applicant been diagnosed with any communicable disease? ☐ Yes ☐ No If Yes, Type_____

Date of last physical exam (attach copy - regulations require one within one year of date of referral):_____

* Explain:

VI. MEDICATIONS

Current (a) medications, (b) dosages, and (c) frequency to include date of last injection:

(a)	(b)	(c)

VII. SUBSTANCE ABUSE HISTORY

Does applicant have a history of substance abuse? ☐ Yes ☐ No If Yes, indicate substance(s) and treatment:

Is there current known substance abuse? ☐ Yes ☐ No If Yes, indicate what substance(s), frequency of use and last known use:

Is applicant on antibuse or any other prescribed medication in conjunction with substance abuse treatment? ☐ Yes ☐ No
If Yes, indicate medication, dosage, and frequency:

What other information may be helpful in relapse prevention?

VIII. LEGAL HISTORY

Does applicant have any current and/or pending charges? ☐ Yes ☐ No If yes, list charges and court dates:

Attorney:_____ Phone_____

Prior legal charges, dates, states, dispositions:

IX. Answer ALL parts of application or N/A when appropriate

This application will not be considered complete without at least the following:

- ☐ Psychiatric Evaluation
- ☐ Psychological Assessment (if available)
- ☐ Discharge Summary (if applicable)
- ☐ Physical Exam
- ☐ Conditional Release (if applicable)

Additional information may be requested as well.

Signature of person completing application: _____

Title:_____ Date:_____

**Transitional Age Youth referrals for minors require a licensed mental health professional signature.*

TAY MINORS: ☐Yes ☐ No The current intensity of outpatient treatment will not be sufficient to reduce the minor's symptoms and functional behavioral impairment resulting from the mental illness and restore the minor to an appropriate functional level, or prevent clinical determination or avert the need to initiate a more intrusive level of care due to the current risk to the individual or others.

For referrals for MHA grant-funded placements in the Transitional-Aged Youth Program only:

CONSENT TO RELEASE INFORMATION

I give my consent to Pathways, Inc. to release this application and other medically necessary information to the Charles County Core Service Agency in order to assess my eligibility for TAY services. I additionally give my consent to Pathways to share statistical information with the Charles County Core Service Agency to enable the authority to monitor the use of services they help to fund.

I understand that this information will not be released to any other party without my express written consent.

I further understand that my consent does not commit me to accept a placement, and it does not commit Pathways to provide a placement for me.

I understand that I may revoke this consent at any time by a written statement. This consent is valid for 12 months from the date of my signature.

Signature of Applicant (Parent or Guardian if applicable): _____

Date: _____

Witness Signature: _____