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Hope House Referral Form
3606 Hecktown Rd , Bethlehem, PA 18020
Phone: 610-882-2008 Fax: 610-882-2009 Web: www.hopehouse-rhd.org

Date of Referral: _____ County Client Case #: _____ New: _____ Reopen: _____
Time of Referral: _____ D.O.B.: _____ SS# _____
Name: _____ Sex: _____ Marital: _____
Street Address: _____ City: _____ Zip: _____ County: _____
Type of Residence: _____ Phone: _____
Who does this person live with? _____ Can person return to this address? Yes/ No
Phone # where the person can be reached: _____ Where is that? _____
Military History [] Yes [] No
*Insurance _____ Insurance Number: _____
Ongoing Caseworker/ICM: _____ CW/ICM Phone#: _____
If the person is involved with RC/ICM/CTT, have they been informed about the referral? Yes/No
Are there any legal issues? Yes/ No If Yes, please explain : _____

Referral Person: _____ Referral Source phone/pager # _____
Name of Referral Organization: _____
Referral Type: (circle one) CTT / ICM / RC / ER / Hospital / Emergency Services/ Mobile Crisis
MH Center / Private Practitioner / Magellan / BSU / Shelter / Other

Please place a check in the box if you would like the treating M.D. to be notified before any med changes occur. []

Criteria for Entry

Does the person want to come to Hope House? [] Yes [] No
Is the person threatening or violent? Currently: [] Yes [] No By History: [] Yes [] No
Does the person have access to weapons? [] Yes [] No
Does the person have thoughts of hurting self or suicide? [] Yes [] No With plan? [] Yes [] No
Describe: _____
Can they contract for safety? [] Yes [] No
Is the person in need of immediate medical attention? [] Yes [] No
Does the person use/ abuse alcohol or drugs? [] Yes [] No Date of Last Use: _____
Substance(s): _____
Pattern of Use (Last 7 days): _____
The individual was last seen by MH or Medical worker (who/when)? _____

Present and Past Psychiatric Services

Last Psychiatric Inpatient Stay: _____
Current Outpatient Services: _____
Treating Psychiatrist: _____ Last Seen: _____
Psychiatric Diagnosis: _____

Medications (include prescribed and over-the-counter): _____

Presenting Problems/ Precipitating Factors

Does the person report trouble with daily functioning? [] Yes [] No

Does the person feel safe at current residence? [] Yes [] No

Describe: _____

Check all that apply:

- [] Oriented P__ P__ T__
- [] Suicidal [] Ideation [] Plan
- [] Homicidal [] Ideation [] Plan
- [] Hallucinations: [] Visual [] Auditory
- [] Paranoid
- [] Delusions
- [] Mood Swings
- [] Poor Motivation
- [] Racing Thoughts
- [] Poor Concentration
- [] Isolating
- [] Agitated/ Irritable
- [] Pacing
- [] Appetite Increase/ Decrease
- [] Sleep Increase/ Decrease
- [] Poor Impulse Control
- [] Decreased ADLs
- [] Blunted Affect
- [] Pressured Speech

Please explain and identify any triggers or stressors : _____

Additional Information

Medical History/ Status: _____

Allergies/ Manifestations: _____

Is the person diabetic? [] Yes [] No

Can they administer their own insulin?

*Insulin Dependent? [] Yes [] No

[] Yes [] No

Is the person on Coumadin or Warfarin? [] Yes [] No

Are they receiving regular lab work? [] Yes [] No

Treating Clinic / Physician: _____

Has the individual ambulation issues? [] Yes [] No

Please Circle: Independent Minimal assistance Significant assistance

Explain: _____

Is the individual independent re: ADLs? [] Yes [] No

If No, Please explain: _____

Name/ Signature of Person Providing/ Taking Referral Info

Date

Please send Face to Face with this Referral Form

PLEASE REQUEST THAT CONSUMER BRINGS THESE SPECIFIC ITEMS:

***Insurance Cards**

*** If Diabetic, please supply insulin orders/ sliding scales.**

***Current Pill Bottles or Physician's Orders**

***Finances to cover co-pays and cigarettes**

Hope House Use Only

Date/ Time Referral was received: _____ Date/ Time Necessary Info was received: _____

Accepted by HH's Staff: Yes/ No*, time: _____ Comments: _____

Person will arrive via: _____ Expected Adm. Date & Time: _____

* Reason why not accepted: _____

Referred to other source/ other outcome: _____

Name/Signature/Title of Person (Not) Accepting Individual

Date: