



REFERRAL FORM

**\*\*If this form is not completed in its entirety, we will be unable to process it. It will be returned to you for completion.\*\***

NOTE TO REFERRAL AGENT: Please follow these steps in referring one of your clients to Threshold.

- 1) Call Threshold at 682-4124. We will take down some brief information to track the referral.
- 2) Threshold will contact your client upon receipt and review of the referral so that s/he may be invited to a scheduled Threshold tour.
- 3) Complete the following referral form.
- 4) **Complete Authorization for Psychosocial Rehabilitation and turn in to UM. Threshold will need to receive the Authorization before orientation can be scheduled.**

5) **Attach the following documents to the referral form:**

- a. **Admission Assessment**
- b. **Order for Service Form**
- c. **Last 3 months of progress notes**
- d. **Current Treatment Plan**

5) Packet can be mailed or faxed to:

Membership Coordinator

PO Box 11706

Durham, NC 27703

Fax (919) 956-7703 (For assurance of confidentiality, please call before sending fax)

DATE: \_\_\_\_\_

DOB: \_\_\_\_\_

RECORD #: \_\_\_\_\_

PERSON REFERRED: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

REFERRAL AGENT: Name: \_\_\_\_\_

Phone: \_\_\_\_\_

PRIMARY CLINICIAN  
(if different from above):

Name: \_\_\_\_\_

OTHER PROVIDERS SERVING REFERRED PERSON (if any):

REASON FOR REFERRAL FOR PSYCHOSOCIAL REHABILITATION:

STRENGTHS/SKILLS OF REFERRED PERSON:

CURRENT PSYCHIATRIC STATUS AND DSMIV DIAGNOSIS (AXIS 1-V) PER ATTACHED PSYCHIATRIC EVALUATION:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

\_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

OTHER SERVICES CLIENT IS RECEIVING:

CURRENT MEDICATION(S):

CURRENT SOCIAL/FAMILY SUPPORT SYSTEM:

CURRENT PHYSICAL HEALTH:

PERTINENT BEHAVIOR PROBLEMS:

Yes No ASSAULTIVENESS

Yes No SUBSTANCE ABUSE

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, please list date of last use, frequency of  
use, and drug of choice: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes No LEGAL INVOLVEMENT

Yes No VIOLENCE TO SELF/OTHERS

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes No GUARDIANSHIP

Yes No STEALING

If yes, please list name, address,  
and phone number of guardian:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

FINANCIAL GUARDIANSHIP ONLY?

Yes No

VOCATIONAL HISTORY:

AMOUNT OF INCOME AND SOURCE:

MEDICAID RECIPIENT? YES NO

If yes, please list MEDICAID #: \_\_\_\_\_

AVAILABLE TRANSPORTATION FOR THIS CLIENT:

- \_\_\_\_\_ BUS
- \_\_\_\_\_ ACCESS
- \_\_\_\_\_ FAMILY CARE HOME/GROUP HOME VAN
- \_\_\_\_\_ OTHER Please specify: \_\_\_\_\_

\_\_\_\_\_

SIGNATURE OF REFERRAL AGENT