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 919-682-4124. 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) **Attach the following documents to the referral form**:
a. **Comprehensive Clinical Assessment or Diagnostic Assessment with PSR as a recommended service.**
b. **Current Supporting clinical documentation (from referring agency and/or Doctor)**
c. **Summary of how the person is doing now.**
6) 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 IDC-10 DIAGNOSIS (AXIS 1-V) PER ATTACHED PSYCHIATRIC EVALUATION:

Primary Diagnosis:______________________________________

Secondary Diagnosis:___________________________________

OTHER SERVICES CLIENT IS RECEIVING:

CURRENT MEDICATION(S) AND DOSAGE:

CURRENT SOCIAL/FAMILY SUPPORT SYSTEM:

CURRENT PHYSICAL HEALTH:

PERTINENT BEHAVIOR PROBLEMS:

Yes No ASSAULTIVENESS

If yes, describe: ______________________
____
____

Yes No SUBSTANCE ABUSE

If yes, please list date of last use, frequency of use, and drug of choice: ____________________
____
____

Yes No LEGAL INVOLVEMENT
If yes, describe: ______________________
____
____

Yes No VIOLENCE TO SELF/OTHERS
If yes, describe: ___________________________
____
____

Yes N o LEGAL GUARDIAN
If yes, please list name, address,
and phone number of guardian:

____
____
____

Yes No STEALING
If yes, describe: ___________________________
____
____

FINANCIAL PAYEE ONLY?
Yes No

VOCATIONAL HISTORY:

AMOUNT OF INCOME AND SOURCE:

MEDICAID RECIPIENT? YES   NO

County of Medicaid origin:________________________

If yes, please list MEDICAID #: ____________________

Social Security #: ________________________________

AVAILABLE TRANSPORTATION FOR THIS CLIENT:
______ BUS
______ ACCESS
______ FAMILY CARE HOME/GROUP HOME VAN
______ OTHER Please specify: ____________________

____

SIGNATURE OF REFERRAL AGENT

Criminal Justice

Is the client currently or have they in the past been involved with the legal system (e.g. on probation, parole, jail, pending charges, court ordered treatment)?
_________ No __________Yes, if yes, explain__________________________________
____
____

Substance Related Disorders

A. Screening for Substance Use

1. Based on a review of available documentation, the community support worker should answer the following:
    a. Referral source indicates the person has a substance related problem
    ____No _____ Yes
    b. Person's medical history indicates past medical condition, hospitalization or emergency room treatment for a substance related medical issue (includes detoxification in the past 2 years) _____No _____Yes
    c. Medication history suggests person is using prescription medicines in inappropriate combination or doses? ______No _______Yes
    d. Person's behavioral health history indicates an episode of substance related treatment in the past 2 years? _______No _____Yes
2. If none of the answers above are yes then depending on the situation ask:
    a. Do you now or have you ever had a problem with alcohol or drugs?
    _____ No _____Yes
    b. Is a spouse/significant other or family member concerned about your use of alcohol or drugs? __________No ____________Yes
    c. If a parent/ legal guardian/spouse/significant other is present ask:
        c (i) Do you feel the person is currently using alcohol or drugs? ___No ___Yes
        c(ii) Has the person gotten into trouble for such use? ______No _____Yes

ONLY complete section B and C below, if the response to any of the question in section A above is yes.

B. Current and Past Substance Use

1. What are your drinking habits? (e.g., How Much, how often and what do you drink? Do you ever drink more than you meat to or feel preoccupied with wanting to drink? Have you neglected some of you usual responsibilities in order to drink? Have you felt you wanted or needed to cut down on drinking or tried to stop but could not? Have you given up or reduced important activities in order to drink?)
    ____
    ____
    ____

2. Have you ever taken any drugs other than alcohol to get high, sleep better, feel better or lose weight? (e.g., How much, how often, how used, and reasons for use? Do you ever use more than you meant to or feel preoccupied with buying drugs or using drugs? Have you neglected some of you usual responsibilities in order to drink? Have you felt you wanted or needed to cut down on or tried to stop but could not? Have you given up or reduced important activities in order to buy or use drugs?)

____

____

____

3. Complete the table below for each substance the person has used in the past 12 months. However, in the far right column indicate primary (p) or secondary (s)for current substance use.

Substance Use	Frequency	Route	Age first used	when last used	Current Use
Alcohol					
Marijuana					
Stimulants					
Opiates/ Narcotics					
Depressants					
Hallucinogens					
Inhalants					
Other Drugs					

Codes for table above

Frequency of Use/Abuse

1 No use in past 30 days
2 1-3 times in the past 30 days
3 1-2 times per week
4 3-6 times per week
5 multiple daily use

Route of administration

1 Oral
2 Smoked
3 Inhaled
4 Injected
5 Other

ABUSE/SEXUAL RISK BEHAVIOR

1. Do you feel safe in your current living situation? ____ Yes ____NO Do you feel safe outside of you home? ____Yes _____NO, if no briefly explain.

____

____

2. Are you currently or have you ever been hurt, harmed, touched inappropriately, or abuse by someone in any way? (Consider any physical, sexual, or emotional abuse) ________No ________Yes, if yes, explain including times when abuse occurred, action taken (e.g., notification of authorities, resulting steps taken).

____

____

3. Is any member of your household/family currently being or has ever been harmed, abuse, neglected, or victimized? (Consider any physical, sexual, or emotional abuse.) ____No _____Yes, if yes explain (including any Adult Protective Services involvement or if any children in protective custody)

____

____

4. Do you engage in any Sexual behaviors that you are concerned about, or that have raised concerns in your family or community (sexually acting out, inappropriate touching, exposure)? ______No _________Yes, if yes explain.

____

____

5. How do you think the issues identified above affect you now?

____

____

____

6. Based on the person's responses, does the assessor feel there an immediate safety risk for the person or others in the household or members of the community? ____No ___Yes, if yes please explain.

____

____

RISK ASSESSMENT

1. Have you ever thought about harming yourself or someone else? ____NO ____Yes, if yes, did you have a plan and when was the last time you thought about harming yourself?

____

____

2. Have you ever harmed/injured yourself or someone else intentionally? ____No ___Yes, if yes, did you have a plan and when was the last time you harmed yourself or someone else? ____

3. Risk of Harm to Self

3(a) indicate which of the following suicide (harm to self) risk factors apply to the person:

Prior suicide attempt ___No ____Yes
Repeated attempts ___No ____Yes
Stated plan with intent ___No ___Yes
Access to Means ___No ___Yes
Substance use ___No ___Yes
Recent Loss ___No ___Yes
History of suicide in Friend ___No ___Yes

Behavorial Cues ___No __Yes
Symptoms of Psychosis __No __Yes
Family history of suicide __No _Yes
Terminal illness ___No ___Yes
Current Stressors ___No ___Yes
Lack of Supports ___No ____Yes

3(b) Provide more detailed explanation for any of the above risk factors that apply.

____

____

4. Risk of harm to others

4(a) Indicate which of the following homicide risk factors apply to the person:

Prior acts of Violence ____No ___Yes
Fire Setting ___No ___Yes
Symptoms of Psychosis ___No ___Yes
Arrests for Violence ____No ____Yes
Physical abuse ____No ___Yes

Substance Use ___No ___Yes
Current Stressors ___No ___Yes
Access to means ___No ___Yes
Agitation ___No ___Yes

4(b) Provide more detailed explanation for any of the above risk factors that apply. ____

____

Identify specific people who may be supportive and helpful to the individual and their rehabilitation. (Include phone numbers) _________________________________

____