CONSUMER NAME: _____ **DATE:** _____

PERSON MAKING REFERRAL/AGENCY_____**CONTACT NUMBER:** _____

E-MAIL ADDRESS: _____

This referral is being made to: Centel Healthcare Inc.
(Check all that apply)

Please Fax Referral To: Admissions
Fax: (804) 591-1543
Office: (804) 767-7787

☐ Intensive In-Home Services ☐ Mental Health Skill Building

☐ Therapeutic Day Treatment ☐ Outpatient Therapy

Identifying Information:

Date of Birth: _____ _____

Sex: _____ Race: _____ _____

Marital Status: Single _____

Social Security #:

Education (last grade completed): _____

Address: _____

Unit #: _____ City:_____ State: _____Zip: _____ _____

Phone #: _____

Current Living Arrangements: _____._____

Income: _____

Income Source: _____ Insurance Name and Policy Number: _____
Does the client have an HMO, if so please list name and policy number: _____

Emergency Contact & Number: _____ ___
_____

Does Consumer have a Power of Attorney or Legal Conservator? ☐ Yes ☐ No If yes, please provide name and contact number: _____

Is Consumer currently under a Mandatory Outpatient Treatment contract? ☐ Yes ☐ No If yes, please provide name and contact number of current treatment facility: _____

Current Treatment Facility/Case Manager/Phone #: _____

Does this consumer have CSB or BHA Case Manager (MH, ID, ALF?) ☐ Yes ☐ No If so, please list CM Name and contact info:_____

Does this consumer have a history of substance abuse? ☐ Yes ☐ No If yes, please describe:

Last Substance(s) used: _____

Last known date of use: _____

Current Medications/Doses/Times Taken: _____

Prescribing Physician:

Agency:

Diagnostic Information (All 5 axes MUST be completed):

Axis 1: _____
(DSM Psychiatric Diagnoses)

Axis 2: _____
(Developmental Disability and/or Personality Disorder)

Axis 3: _____
(Medical Diagnoses)

Axis 4:
(Environmental Stressors)

Axis 5: _____ _____
(GAF) Current Highest Lowest

Please list all hospitalizations that the consumer has had over the past **12 months**. It is important to be as detailed as possible to ensure that the person will be accepted.

Hospital	Admission Date	Reason for Admission	Discharge Date

Does Consumer have a history of suicidal, violent or aggressive behavior? ☐ Yes ☐ No If yes, please describe:

_____.

Has the Consumer had any involvement with the judicial system? ☐ Yes ☐ No If yes, please describe:

_____

Referral Source Signature:_____ Ph:_____ Email:_____