Shalom House, Inc.
106 Gilman Street
P.O. Box 560
Portland, Maine 04112

PROFESSIONAL REFERRAL

Date ___________________

Client Name _________________________________ Date of Birth ________________________
SS# ________________________
Address _________________________________ Phone ________________________
_________________________________ MaineCare ___Yes ___No
_________________________________ MaineCare # ________________________
Medicare ___Yes ___No
Medicare # ________________________

Guardian ___Yes ___No Guardian name______________________ Phone __________________
ICM/CSW____ Phone __________________

Marital Status ________ Employment Status ________
Veteran Status ________ Income ________
Male/Female: ________ Income Source ________
Class Member: ___Yes ___No Primary Language ________
Citizenship ___Yes ___No Education Level ________

Psychiatrist_______________________ Agency________________________ Phone ________________
Therapist_________________________ Agency________________________ Phone ________________
Referred by ______________________ Agency________________________ Phone ________________

I am referring for:
____Community Integration Services (Case Management)
____Transitional Group Home (Park St.)
____Long-term Group Home (O'Brion, Clark & Wilson St.) (by DHHS/state hospital referral only)
____Transitional Supported Housing (Forest Ave. Read St. & Auburn House)
____Long-term Supported Housing (Apts: Brannigan House & Congress St.) (Rooming Houses: Spring, Vaughan & Brackett St.)

**If referring for TRANSITIONAL housing, please complete below.*

Estimated length of stay: ____

Describe previous housing: ____
____
____

Housing plan after transitional support: ______________________________
____

Needs to accomplish this plan: ____
____
____
____

If self referral, how did you hear about Shalom? ________________________________

Reason for Referral (include current situation and why this person is qualified): ______________________________

Hospitalization History (include dates): ______________________________

Medical Conditions/Allergies: ______________________________

Substance Abuse History: ____Yes ____No Currently Using: ___Yes ___No
If yes, describe ______________________________

Current Medications: ______________________________

History of harm to self/others (include dates): ______________________________

Describe any legal involvement (include probation): ______________________________

What strengths has the individual demonstrated: ______________________________

Recommendations (while receiving services/housing): ______________________________

All applications must include the following information:

Client Name: ____________________ Date of Birth: ___/___/___

DSM-IV Name: **Diagnostic Code:**

AXIS I ____ ____________

____ ____________

AXIS II ____ ____________

AXIS III ____

AXIS IV ____Problems related to the Interaction w/Legal System ____Educations Problems
____Housing Problems ____Occupational Problems ____Problems related to the Social Environment
____Other Psychosocial and Environmental ____Problems with access to Health Care
____Economic Problems ____Problems with Primary Support Group

AXIS V (GAF Score) __________________________________
LOCUS Score __________________________________

Note: To be eligible for Section 17 Community Integration services, an individual must be a class member or have at least one of the following consequences that result from signs and symptoms of the client's psychiatric diagnosis*(see footnote, below)

___Has become homeless or is at risk of losing his or her current residence.
___Is causing repeated disturbances in the community because of poor judgment or bizarre, intrusive, or ineffective behavior.
___Is at great risk of arrest because of behavior which results from his or her psychiatric diagnoses, or is presently incarcerated because of such behavior.
___Presents a clear risk of harming self or others without Community Support Services.
___Manifests great difficulty in caring for self, posing a threat to his or her life or limb, without Community Support Services.
___Would deteriorate clinically to a point of needing immediate medical or psychiatric hospitalization in the absence of prompt Community Support Services.

____ _____________________________________

Signature of Diagnosing Clinician **Date diagnosis administered**
(must be made within the last 12 months)

____ _____________________________________

PLEASE PRINT NAME AND CREDENTIAL **Agency/Facility/Practice**

*Please note that the diagnosis must be other than:
a. Delerium, dementia, amnestic, and other cognitive disorders/
b. Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
c. Substance abuse or dependence;
d. Mental retardation;
e. Adjustment disorders; V-codes; or
f. Antisocial personality disorders.