Shalom House, Inc.
106 Gilman Street
Portland, Maine 04102

PROFESSIONAL REFERRAL

☐ **Community Rehabilitation Service (CRS)**

Date _____

Client Name _____ Date of Birth _____
SS# _____
Address _____ Phone _____
_____ MaineCare ☐Yes ☐No
_____ MaineCare # _____
Medicare ☐Yes ☐No
Medicare # _____

Marital Status _____ Employment Status _____
Veteran Status _____ Income _____
Male/Female/TG _____ Income Source _____
Class Member: ☐Yes ☐No Primary Language _____
Citizenship ☐Yes ☐No Education Level _____

Guardian ☐Yes ☐No Guardian name_____ Phone _____

Rep. Payee_____ Phone _____

PCP_____ Agency_____ Phone _____

Psychiatrist_____ Agency_____ Phone _____

Therapist_____ Agency_____ Phone _____

Referred by _____ Agency_____ Phone _____

Reason for Referral (include current situation and why this person needs this services):

_____

_____

_____

_____

How often does the consumer need program contact? (CRS only)

_____

_____

Why does he/she need this frequency? (CRS only)

_____

_____

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: _____

_____

_____

_____

All applications must include the following information:

Client Name _____ Date of Birth: __/__/____

Initial Certification Date: __/__/__ or Recertification Date: ___/___/___

DSM-5 Name:	**Diagnostic Code:** *ICD-10 Codes only*
Primary Diagnosis:_____	_____
Secondary Diagnoses:_____	_____
_____	_____

Medical Diagnoses: _____

If primary diagnosis is other than Schizophrenia or Schizoaffective Disorder, please indicate the client has at least one of the following consequences resulting from signs and symptoms of their psychiatric diagnosis (The diagnosis causing this consequence must be other than: Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder, Substance Abuse Disorders). Check all that apply:

___Has received treatment in a state psychiatric hospital, within the past 24 months
___Has been discharged from a mental health residential facility, within the past 24 months
___Has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past
24 months
___Has been committed by a civil court for psychiatric treatment as an adult
___Until the age 21, the recipient was eligible as a child with severe emotional disturbance*
*If selecting this qualifier, please indicate a written opinion stating that the recipient, in the last 12 months, had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

_____
_____
_____
_____

___Provide a written Clinical Letter stating that, based on documented or reported history, client is likely to have future episodes, related to mental illness, that would result in or have significant risk factors of homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided. Reported history may include oral or written history from the client, a provider, or a caregiver.

_____ _____

Signature of Diagnosing Clinician (must be MD, LCSW, , LCPC, PHd, APRN, NPC or DO)

Date diagnosis administered *(must be made within the last 12 months)*

_____ _____

PLEASE PRINT NAME AND CREDENTIAL

Agency/Facility/Practice