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

# PROFESSIONAL REFERRAL

☐ **Community Integration Services**
☐ **Community Rehabilitation Service (CRS)**

**Supported Housing Choices:**

| | | |
|---|---|---|
| ☐ **Brackett St.** | ☐ **Congress St.** | ☐ **Spring St.** |
| ☐ **Brannigan House** | ☐ **Vaughan St.** | ☐ **Own Apartment** |

Date ____________________

Client Name ____________________________________

Address ____________________________________
____________________________________
____________________________________

Date of Birth ____________________________
SS# ____________________________
Phone ____________________________
MaineCare ☐ Yes ☐ No
MaineCare # ____________________________
Medicare ☐ Yes ☐ No
Medicare # ____________________________

Marital Status _________
Veteran Status _________
Male/Female/TG _________
Class Member: ☐ Yes ☐ No
Citizenship ☐ Yes ☐ No

Employment Status _________
Income _________
Income Source _________
Primary Language _________
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 opinion 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. **The documented or reported history can be in the form of risk factors rather than actual past episodes.**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

_____________________________________________ _____________________________________

**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**