# Monmouth Behavioral Health Home
# REFERRAL FORM

1215-1217 Main Street Asbury Park NJ 07712
P: 732-380-0390

**FAX REFERRAL TO 908-852-2255**

**Date:** _____

**Referral Source:** _____

**Submitted by:** _____

**Phone Number:** _____

**How did you hear of us?** _____

**Name of Person Being Referred:** _____

**Name of Guardian (If applicable):** _____

**Phone Number:** _____ **Relationship to Individual:** _____

**Home Address:**

_____

_____

**Current Address:** IF DIFFERENT FROM HOME ADDRESS
(for hospital referrals, include unit and Social Worker)

_____

_____

**Date of Birth:** _____ **Primary Language:** _____

**Social Security #:** _____ **Marital Status:** _____

**Race / Ethnicity:** _____ **Emergency Contact:** _____

**Medicaid #:** _____ **Phone Number:** _____

**1. DSM V DIAGNOSIS - CODE & DESCRIPTION**

| | |
|---|---|
| | |
| | |

**2. Medical or Mental Health Hospitalizations (list 5 most recent, including current)**

| Name of Institution | Admission Date | Discharge Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**3. MEDICAL (if applicable):**

Diagnosis: _____

Treating Physician: _____
(Name) (Address) (Phone)

Allergies: _____

**4. CURRENT MEDICATIONS:**

| Medication | Dose / Route / Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |

**5. HISTORY OF DRUG AND/OR ALCOHOL ABUSE (please give details):**

_____
_____
_____

**WHAT WAS LAST USE AND WHEN**_____
**BHH ACTION PROVIDED**_____

**6. [ ] HISTORY OF SUICIDAL IDEATION/PLANS/ATTEMPTS (please include dates and details) [ ] PRESENT SUICIDAL IDEATION/PLAN/ATTEMPT:**

_____
_____

**7. HISTORY OF AGGRESSIVE AND/OR VIOLENT BEHAVIOR (please give details):**

_____
_____

**8. IS CONSUMER CURRENTLY ON KROL STATUS (found not guilty of criminal charges due to a mental illness)?**

- ☐ **YES** If Yes, Please Explain: _____
- ☐ **NO**

**9. PENDING LEGAL CHARGES/ PAROL/ FEES**

_____
_____

**10. Presenting Problems:**

_____

_____

_____

**11. Any Urgent or critical needs:**

_____
_____
_____

**BHH Action Provided**:_____

**12. RESOURCES (Please list amounts if known):**

- ☐ SSI _____
- ☐ SSD _____
- ☐ SSA _____
- ☐ AFDC _____
- ☐ Rent Asst: _____
- ☐ Gen. Asst: _____
- ☐ VA _____
- ☐ Payee: _____
- ☐ Other: _____

**13. WILL SPECIAL ACCOMODATIONS BE NEEDED TO COMPLETE THE ASSESSMENT PROCESS?**

If Yes, Explain: _____

**14. TYPES OF SERVICES SOUGHT/ SERVICES SOUGHT BY CONSUMER: (check all that apply)**

| | | |
|---|---|---|
| ☐ Crisis Stabilization/ Emergency Services | ☐ Community Residential Program( with MH svcs) | ☐ Coping Skills/ Stress Management |
| ☐ Primary Care Physician | ☐ Crisis Housing | ☐ Wellness Recovery Action Plan |
| ☐ Social Supports | ☐ Outreach/ In-Home Services | ☐ Behavioral Supports |
| ☐ Client Advocacy/legal | ☐ Residential Support Services | ☐ Career Planning |
| ☐ Daily Living Skills | ☐ Medication Education | ☐ Assistance with Advanced Directive |
| ☐ Psychiatric Prescriber | ☐ Pre-Vocational Services | ☐ Dental Care |
| ☐ Partial Care | ☐ Employment | ☐ Eye Exam |
| ☐ Addiction Services | ☐ Nutritional Education | ☐ Vaccinations/Prevention Medicine |
| ☐ Psychotherapy Counseling | ☐ Exercise Plan | ☐ Self-Monitoring devices (glucometer, BP, Pulse ox) |
| ☐ Self-Help Services | ☐ Diagnosis Education | ☐ Transportation |
| ☐ Service Coordination/Linkage | ☐ Information and Referral | ☐ Other _____ |

***FOR OFFICE USE ONLY***

*Date Received:*_____ *Staff Name:* _____

*Date of 1st Contact w/Referring Party* _____ *Name of First Contact:* _____

*Disposition:*_____

*Check One:*

□ *Accepted* □ *Denied and alternate resources were provided.* □ *Pending*

*Staff Signature:* _____ *Date:* _____

# EASTERSEALS NEW JERSEY
# AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I hereby authorize Easterseals New Jersey to (check one or both as it applies)

- ❑ disclose to
- ❑ request from

_____

(Specify individual, agency, organization, and address)

The following information regarding (name of individual receiving services): _____

_____

(Address)

_____

(Date of birth) (Social Security Number)

for the purpose of _____

Dates of services _____

Information to be disclosed or requested: CHECK AND INITIAL **ONLY THOSE WHICH APPLY**

| | |
|---|---|
| ❑ _____Assessment | ❑ _____Service agreement |
| ❑ _____Behavior contract or plan | ❑ _____Service plan |
| ❑ _____Criminal history | ❑ _____Social assessment |
| ❑ _____Discharge summary | ❑ _____Social security information |
| ❑ _____Financial information/earnings | ❑ _____Work adjustment training report |
| ❑ _____Intake assessment | ❑ _____Physical health assessment |
| ❑ _____Interagency communication | ❑ _____Prevocational evaluation report |
| ❑ _____Psychiatric assessment | ❑ _____Legal information |
| ❑ _____Psychological assessment/testing | ❑ _____Placement report |

I understand that this may include (as applicable) information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, and/or treatment for alcohol or drug abuse.

The information will be released in this format (circle all that may apply): written verbal fax electronic other (specify)_____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire within one year from the date of the signature, or on the following date, event, or condition, whichever is sooner:

_____

I hereby release Easterseals New Jersey, its employees and officers from any legal responsibility or liability for disclosure of or receipt of the above information to the extent indicated and authorized.

I understand that Easterseals New Jersey may not condition services or payment on whether I sign this authorization.

I understand that there is a potential for information disclosed under the authorization to be subject to redisclosure by the recipient and no longer protected.

Signature: _____

(Individual receiving services) (Date)

_____

(Or legal representative) (Relationship to individual served) (Date)

_____

(Signature of witness for Easterseals) (Date)