Short Term Crisis Respite Referral Form

Name: _____ Referral Date: _____

Gender: ☐ M ☐ F ☐ Other Date of Birth: _____

Address: _____

Phone: _____ Social Security #: _____

Health Insurance Provider: _____

ID#/CIN#/Medicaid # _____

Care Manager: _____

Referral Source: _____

Phone #: _____

E-mail: _____

Mobile Crisis Referral: ☐ Y ☐ N

If yes, complete **PART A** only.

PART A:

Can the person safely be diverted from the ED or hospital?	☐ Y	☐ N
Is the person homeless?	☐ Y	☐ N
Does the person need handicap accessibility?	☐ Y	☐ N
Is person a registered sex offender?	☐ Y	☐ N
Is the person under the influence or at risk of withdrawing from any substances?	☐ Y	☐ N
If yes, what substances? _____		
Does the person suffer from any chronic medical conditions?	☐ Y	☐ N
If yes, what condition(s)? _____		
Can the person take care of their personal needs without assistance?	☐ Y	☐ N
Will the person have reliable transportation during the respite stay?	☐ Y	☐ N
Does the person have a diagnosis of TBI, dementia, or any organic brain disorder?	☐ Y	☐ N

Mental Health Diagnosis: _____

_____

Taking Medications for above condition? ☐ Y ☐ N Medication(s): _____

Description of Current Crisis:

PART B:

What supports are needed during the stay and any specific goals that will aid in the person's success?

Is there any dietary preferences, need, and/or food allergies? _____

_____

Discharge Address: _____

_____

Contact Person's Name: _____

Contact Person's Phone: _____

Current housing safe and stable? ☐ Y ☐ N

Office Use Only:

Housing Verified? ☐ Y ☐ N

Madison	**Onondaga**	**Oswego**
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Office Use Only:

Date received: _____ Accepted: ☐ Denied: ☐

Staff Name: _____

Notes: