



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

Can the person follow fire safety protocol? Y N

Mental Health Diagnosis: _____

Taking Medications for the 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

Phone: (315) 280-0384

Fax (315) 820- 0191

Madisoncrisisbeds@liberty-resources.org

Onondaga

Phone: (315) 870-3740

Fax: (315) 565-2809

Onondagacrisisbeds@liberty-resources.org

Oswego

Phone: (315) 216-4320

Fax: (315) 741-5202

Oswegocrisisbeds@liberty-resources.org

Office Use Only:

Date received: _____

Accepted:

Denied:

Staff Name: _____

Notes: