LIBERTY RESOURCES

Onondaga
fax (315) 565-2809
Onondagacrisisbeds@liberty-resources.org

Madison
fax (315) 820-0191
Madisoncrisisbeds@liberty-resources.org

Oswego
fax (315) 741-5202
Oswegocrisisbeds@liberty-resources.org

Cayuga
fax (315) 409-7836
Cayugacrisisbeds@liberty-resources.org

Crisis Stabilization 1-855-778-1900

Respite & Intensive Support Services Referral Form

Name:_____ Preferred Name: _____ Referral Date:_____

Gender: ☐ Male ☐ Female ☐ Other_____

Age:_____ Date of Birth:_____Social Security #:_____

Address: _____ County:_____

Phone: _____ Contact Person/Phone #: _____

Health Insurance Provider: _____ID#/CIN (Required):_____

HARP (ePACES): Enrolled (H1) ☐ Eligible (H9) ☐ Neither ☐

Referral Source & Role:_____Phone #: _____

If applicable, Agency:_____

If applicable, signature to Authorize Services or Transportation:_____

THIS REFERRAL FORM IS INTENTED TO BE COMPLETED WITH THE PARTICIPANT/GUEST

PART A: *Required for ALL Crisis Services*

The following questions *MUST be answered by the Participant/Client. If the participant is unavailable, the referral source should complete the questions below to best of their ability. The information below is collected to determined required level of support and intervention.*

In the last month:

1) Have you wished you were dead or wished you could go to sleep and not wake up? Yes ☐ No ☐
2) Have you actually had any thoughts of killing yourself? Yes ☐ No ☐
3) Have you ever experienced violence or trauma in any setting? Yes ☐ No ☐

If YES to any of these questions, the Columbia Suicide Severity Rating Scale will be completed at admission.

Primary Mental Health Diagnoses:

Substance Use Disorder Diagnoses: Yes ☐ No ☐

Description of current crisis and/or any safety concerns:

Interested in Crisis Respite? *Continue completing B-C.* Yes ☐ No ☐

PART B: *Required for Crisis Respite*

In the last 14 days:

Have you traveled outside of New York State? Yes ☐ No ☐

Have you been placed on active isolation or quarantine status or been in direct contact with anyone who has? Yes ☐ No ☐

Do you currently have any COVID-19-like symptoms or been around someone who does? (*i.e. fever or chills, cough, difficulty breathing, loss of smell or taste*) Yes ☐ No ☐

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Preferred Respite: Onondaga ☐ Madison ☐ Oswego ☐ Cayuga ☐

Is the person under the influence or withdrawing from any substances? Yes ☐ No ☐

If yes, what substances?_____

Last day used:_____

Can this person take care of their personal needs without assistance including following fire safety protocol or do they require handicap accessible?

Does the person require medical intervention or suffer from seizures? Yes ☐ No ☐

Part C: *Required for Crisis Respite (Exclude Mobile Crisis Referrals)*

Will the person have reliable transportation during the respite stay? Yes ☐ No ☐

Will the person be bringing medications? Yes ☐ No ☐

Is the person a registered sex offender? (If applicable, review Offender Registry) Yes ☐ No ☐

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

Peer Support ☐ Linkages & Referrals ☐ Relapse Prevention Planning ☐ Health & Wellness Activities ☐

Other:_____

Food Allergies:_____

Viable Discharge Plan:_____

_____

Office Use Only

Intensive Support Services Eligibility:

At least 25 yrs old & answered "yes" to at least 1 question in Part A Yes ☐ No ☐

Crisis Respite Eligibility:

Viable Discharge? Yes ☐ No ☐ COVID-19 Temperature Reading:

Approved for Admission ☐ Denied Admission ☐ Pending Admission Decision ☐ Guest Declined Admission ☐

Evolv Status: Accepted Initials:_____ Denied Initials:_____ Pending Initials:_____

Status Reason: No Safe & Stable Discharge Plan ☐ High Acuity w/Psychiatric Needs ☐

Requires Medical Intervention ☐ At Risk for Withdrawal ☐

Staff Name: _____

Notes: