Post Crisis Engagement Navigator (PCEN) Service Referral

Today's Date: _____

REFERRAL SOURCE

CONTACT: PostCrisisNavigator@liberty-resources.org

Referral Source Type (select one):

- ◉ Correctional Facility/Jail
- ○ CPEP
- ○ Emergency Dept
- ○ EMS
- ○ E-911
- ○ Housing Shelter
- ○ ICSC
- ○ LGU / SPOA
- ○ Mobile Crisis
- ○ Outreach
- ○ Law Enforcement
- ○ Parole / Probation
- ○ Psychiatric Inpatient
- ○ OTHER:

Referring Agency (select one):

- ◉ Fulton City Police
- ○ Helio Health
- ○ Liberty Resources
- ○ NYS Troopers
- ○ Oswego City Police
- ○ Oswego County DMH
- ○ Oswego County Jail
- ○ Oswego County Opportunities
- ○ Oswego County Sheriff
- ○ Oswego Hospital
- ○ St. Joseph's Hospital
- ○ Village Police
- ○ OTHER:

Your Name _____

Your Title _____

Your Phone _____

Your E-Mail _____

REFERRAL ELIGIBILTY SCREENING

The PCEN supports Adults, Youth age 13+ (and their families) who have three (3) or more of the following crisis interventions or services within the past three (3) months.

Please provide the crisis intervention history, as known to you, for the referred person:

Number of known Behavioral Health ED visits in the past 90 days?
■ 1 ☐ 2 ☐ 3 ☐ 3+ ☐ unknown

Number of known Mobile Crisis Call-Outs in the past 90 days?
☐ 1 ☐ 2 ☐ 3 ☐ 3+ ☐ unknown

Number of known Intensive Crisis Stabilization Center (Helio, Syracuse) visits in the past 90 days?
☐ 1 ☐ 2 ☐ 3 ☐ 3+ ☐ unknown

Number of known Psychiatric Inpatient Admissions in the past 90 days?
☐ 1 ☐ 2 ☐ 3 ☐ 3+ ☐ unknown

Number of known SUD Inpatient Admissions in the past 90 days?
☐ 1 ☐ 2 ☐ 3 ☐ 3+ ☐ unknown

Number of known Law Enforcement Transports (9.41, 9.45, 9.58) for an Emergency Mental Health Evaluation in the past 90 days?
☐ 1 ☐ 2 ☐ 3 ☐ 3+ ☐ unknown

Number of known EMS responses related to Mental Health or Substance Use in the past 90 days?
☐ 1 ☐ 2 ☐ 3 ☐ 3+ ☐ unknown

REFERRED PERSON (provide as much information as possible)

First & Last Name: _____

DOB (must be age 13+): _____ /_____ /_____

Sex at Birth (choose one): ☐ Female ☐ Male ☐ Unknown

Street Address, Location where person can be contacted, or Last known whereabouts:

_____

_____

_____

_____

Mailing Address (if different from above):

_____

_____

_____

_____

Phone: _____

Current Living Situation:

- ☐ Homeless
- ☐ Lives with Others
- ☐ Unknown
- ☐ Lives Alone
- ☐ Lives in a Supervised Residential Setting
- ☐ Other:

Alternate Contact Person:

Name _____ Phone _____

If currently in hospital or jail, provide facility name & anticipated discharge date:

Facility _____

Discharge / Release Date _____

Mental Health Conditions / Concerns

_____

_____

Substance Use Concerns

_____

_____

Current Service Providers (outpatient treatment, care manager, case worker, physician, etc.)

Name	Agency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Programs or Supports

_____

_____

_____

_____

_____

Does the referred person know you are making this referral?

☐ Yes ☐ No ☐ Other: _____