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: ______________________