www.anglezbhs.com 1-844-294-5306 Office 1-844-294-5306 fax

Psychiatry: ____MH OPT ____COMP ASSESS **Referral Form** Referral

Date:

Adult: ____CM ___DLS ___SKILLS

Children: ____Child 's CM ___HCT Required: Complete SECT 65 HCT referral packet Attached

Interpreter Services needed: ___Yes ___No

ARE YOU RECEIVING ANY SERVICES FROM ANOTHER AGENCY? IF YES, WHO: ____________________________

Individual Requesting Services: Phone Number:

Relation to Applicant:

Name of person completing this form:

Demographics (Name as it appears on Insurance card)

First:	Last:	M:
DOB	SSN:	Gender:
Race (optional):	Medicare#:	MC#
	Primary Ins Group#:	Primary Ins Group#:

Current Residence:

Street:			
Town:	State:	Zip:	Phone:

DSM—IV Primary Diagnosis, LOCUS, and GAF

AXIS 1 (ICD-10)	LOCUS:	GAF:

Must have a DX of Schizophrenia or Schizoaffective Disorder to be eligible for section 17 services

OR

Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:

_____a) documented history, stating that he/she is likely to have: future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support services are provided; based on need: rental history; or

_____b) has received treatment in state psychiatric hospital, within the past 24 months, :or has a non-excluded DSM-IV 5 diagnosis; or

_____c) has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or

_____d) has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months, for a non- excluded DSM 5 diagnosis: or

_____e) has been committed by a civil court for psychiatric treatment as an adult;

_____f) until the age of 21, the recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a clinician, in the last 12 months, stating that the recipient had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided

Parent/Guardian Information

☐**Own Guardian (Age 18+)** ☐ **Parents Married & Living Together** ☐ **Shared Custody (both must sign paperwork)**

☐ **Sole Custody (Copy of Custody Agreement or PFA)**

Parent/Guardian	☐ Residency
Address:	Phone
Parent/ Guardian	☐ Residency
Address:	Phone:

☐ Copy of Diagnosis Attached