**COMMUNITY FRIENDSHIP, INC.**

**85 Renaissance Parkway, N.E.**

**Atlanta, GA 30308**

**404-875-0381 (fax) 404-875-8248**

**REFERRAL FORM**

**Please answer the following questions as completely as possible:**

**Consumer Information**

**Name of Consumer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_**

**What is the consumer's source and amount of income? Gen. Asst. $ SSI $ SSDI $ Other $ None\_\_\_\_\_\_\_\_**

**Medicaid # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Where and with whom does the consumer live?**

**Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ ZIP: County:\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:**

**Do they have a DBHDD Housing Voucher?**  Yes No

**Employment /Educational Information**

**What jobs/employment has the consumer had?**

## Job Title Length of Employment Reason for Leaving

**From - To**

**\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the consumer's educational background? Highest year completed Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special/vocational training Yes\_\_\_\_ No\_\_\_\_ What \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatric Hospitalization/Mental Health Services**

**Has the consumer ever been hospitalized for psychiatric illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, provide the following information:**

**1. Most Recent Hospitalization: Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Admitted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Discharged:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. Previous Hospitalization**

**Hospital City Date Contact Person**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the consumer currently participating in outpatient psychiatric treatment? \_\_\_\_\_\_\_\_\_\_**

**If yes, provide the following information:**

**Mental Health Center/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*Primary DSM 5/ICD 10 code: \_\_\_\_\_\_\_\_\_\_Diagnosis name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please attach supporting documents of the diagnosis that are within the last 12 months of this referral: i.e. Diagnostic Assessment.***

# 

**What services are being provided?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the name and dosage of prescribed medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\**If the consumer is currently an in-patient, please answer the questions on medications and please indicate the mental health center that will provide outpatient services upon discharge.***

**\*\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician/Licensed Psychologist/LCSW/LPC or APRN Signature Physician/Licensed Psychologist/LCSW/LPC or APRN Printed Name**

**Substance Abuse History**

**Does the consumer have a history of drug or alcohol abuse?**

**Has the consumer ever been hospitalized for drug or alcohol abuse? If yes, provide the following information:**

**1. Most Recent Hospitalization: Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Admitted: Date Discharged: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary DSM 5/ICD 10 code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Diagnosis name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the consumer currently participating in outpatient substance abuse treatment?**

**If yes, provide the following information:**

**Treatment Center**

**Contact Person Telephone # \_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long in Treatment?**

**Other Community Program Involvement**

**Is the consumer currently participating in or receiving benefits from other community programs? If yes, provide the following information:**

**Name of Program Telephone # \_\_\_\_\_\_\_\_\_\_**

**Contact Person \_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What services are being provided?**

**Does consumer have a Rehabilitation Services Counselor? If yes, give name of counselor Telephone**

**Does consumer have physical, medical problems, special diet, or allergies requiring special attention?**

**If yes, please describe \_\_\_\_\_\_\_**

**What specific goals do you and the consumer expect to be achieved through participation at CFI? For VR clients, please indicated work goal.**

At present, what is the consumer’s primary need? Please check ONE of the following services that would address this need. NOTE: referral to one department allows consumer access to other departments as needed.

Homeless Outreach & PATH (Community Linkage, Entitlements, etc.)

Housing(Group Homes & Supervised Apts)

*We cannot accept applicants for Housing who have been evicted from federally-assisted housing within the last three years for drug-related criminal activity; a person who is subject to a state lifetime sex offender registration program (HUD properties only); a person who abuse or pattern of abuse of alcohol interferes with the health, safety, or right to peaceful enjoyment of the premises by other residents. We will ask applicants to comply with a criminal history check.*

**Supportive Services at Phoenix House, O’Hern House, Rosalynn & Presley Woods** (\* Individuals must be a current resident of one of these properties).

PSR Day Services(Work Adjustment, Vocational Evaluation, Day Services, Work Evaluation, Personal & Social Adjustment, Food, Transportation) \*PSR-Psychosocial Rehabilitation

Supported Employment (*\*Task Oriented Rehabilitation Services(TORS)* (Work Opportunities services including Work Exploration, Job Coaching, Job Placement, Follow Up. \*TORS:For *TORS*, individuals must meet eligibility requirements)

Please check one: Meets ADA criteria listed in ICM below Does not meet ADA criteria

**Peer Support**( Recovery, Wellness, Daily Living Skills, Socialization and WHAM)

**Intensive Case Management (ICM) & Community Transition Planning (CTP):** Individuals with SPMI who meet following ADA criteria:

Please check those that apply:

\_\_\_\_\_ Currently served in the State hospitals

\_\_\_\_ Frequently admitted to the State hospitals, I.e.

--3+ hospitalizations in a 12 month period;

--10+ hospitalizations in lifetime;

--less than 30 day hospital readmissions;

\_\_\_\_ Frequently seen in Emergency Rooms;

\_\_\_\_ Chronically homeless;

\_\_\_\_ Being released from jails or prisons; AND/OR

\_\_\_\_ In forensic status and deemed appropriate for community services by relevant court

**Referral Agency**

**Contact Person**

**Address**

**Telephone**

**Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Person completing the referral form: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*PLEASE NOTE THAT A CRIMINAL RECORDS CHECK MAY BE NECESSARY TO ACCESS CERTAIN CFI SERVICES\*\***

Revised 7/19/18