E.S.P. Case Management Professionals, Inc.
687 Beville Road
South Daytona, FL 32119
386-760-7533 Fax 386-761-5868

REFERRAL FORM

Client Name and # _____

Date: _____

REFERRING AGENCY: _____

Referred by: _____Phone Number: _____

Address: _____Email: _____

SERVICES REQUESTED: _____

CLIENT INFORMATION:

Name: _____

Address: _____City:_____

Phone: _____Cellular: _____Email: _____

Gender: ____M ____F D.O.B: _____Age: ____SSN: _____

Source of Income: _____ Monthly Amount: _____

Food Stamps: Yes _____ NO_____ Monthly Amount: _____

Military Service: Yes _____ NO _____ Type of discharge: _____

Parent/Guardian (if applicable): _____

Relationship: _____Telephone: _____

HISTORY OF HOMELESSNESS:

Current Living Conditions: _____How Long: _____

Length of Homelessness: _____How many times homeless in the past three years:_____

MENTAL HEALTH HISTORY:

Mental Health Diagnosis _____

Present Treatment for Mental Health (agency and location) Medications/Dosage: _____

_____

_____

Recent hospitalizations (within the past year) Yes _____ No _____ If yes, date and reason: ____

_____

Doctor/Therapist Name/PhoneNumber:_____

_____

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DISABILITY HEALTH HISTORY:

Disability Health Diagnosis: _____

Disability Certification Statement attached ____Yes ____No

Present Treatment for Disability (agency and location) Medications/Dosage: _____

_____

_____

Recent hospitalizations (within the past year) Yes _____ No _____ If yes, date and reason: ____

_____

_____

Doctor/Therapist Name/PhoneNumber:_____

_____

MEDICAL:

Medicaid: Applied for: ___Yes ___ No ___Accepted ___Denied ___

Receiving ___ Number _____

Applied for SSI: _____Yes ___ No ___Accepted _____Denied _____Receiving _____

Applied for SSDI: _____Yes ___ No ___Accepted _____Denied _____Receiving _____

Insurance (Name of Provider) _____Policy#_____

Name and Location of Primary Care Physician: _____

_____

Medical Condition (including allergies): _____

_____

Medications taken for any medical condition: _____

_____

_____

Any recent hospitalizations (within the past year) Yes ____ No ____ if yes, date and reason: _____

_____

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Smoke Cigarettes: Yes _____ No _____

Substance Abuse History:

How often does client use alcohol? _____How often does client use other non-prescribed controlled substances? _____

Has there been use of controlled substance within the past year? Yes ____ No ___Unknown _____

Drug(s) of choice: _____Present Treatment for Substance Abuse (agency and location), _____

Counselor: _____ Past Treatment (inpatient or outpatient) for substance abuse: _____

FORENSIC HISTORY:

Does client have any charges or convictions related to Sex Abuse? Yes ___ No ____

Does client have any Felony Convictions? Yes ___ No ___

Is client currently on Probation or Parole? Yes ___ No ___

Has client ever been incarcerated for more than two (2) years? Yes ___ No ___

Does client have any pending Legal Charges? Yes ___ No ___

LIVING SKILLS:

Housing History and Patterns (Including timelines for homelessness if possible): _____

_____

_____

Activities of Life (Hygiene, Housekeeping, Budgeting, etc.): _____

_____

Social Skills and Needs (Family Support, Social Functioning, Privacy Needs, etc.): _____

_____

Other Comments or Concerns: _____

_____

_____

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Certification Statement

I certify that this statement is true to the best of my knowledge and belief. I have attached all necessary documentation to support that the information provided is accurate.

_____ _____

Signature Date

_____ _____

Title Phone Number

Agency: _____

To be completed by RECEIVING STAFF:

Date Referral was Received: _____

Date of Follow-up Phone Call or Interview: _____

Determination: Referral Accepted _____ Rejected _____ Date: _____

If Referral is Rejected, state Reason: _____

_____

Staff Signature: _____