MHA OF DUTCHESS COUNTY: PROS REFERRAL FORM

451 Fishkill Avenue Beacon, NY 12508

Phone #: (845) 831-2124 Fax #: (845) 831-1373 DATE OF REFERRAL_____

Participant Name: _____

DOB: _____

Address: _____

_____

_____

Phone#: _____

Medicaid#: _____

MCO:_____

ID:_____

Medicare#:_____

All participants must have a **SPMI**

Primary Psychiatric Diagnosis:

_____

Secondary Psychiatric Diagnosis:

_____

Substance/Alcohol Abuse:

_____

Medical Diagnosis:

_____

Is the Individual Flagged? **Yellow** (Allergy) ___ **Green** (Medical) ___

Red (Hx/current danger to others) ___ **Blue** (Hx/current danger to self) ___

(If YES, attach a copy of flaggings)

Flaggings are a mechanism to identify HX of violence towards self or others, allergies or conditions.

If your program does not require flaggings please make sure to include this history in the narrative of this referral.

Date of Last Psychiatric Hospitalization: _____

How many Psychiatric Hospitalizations in the past 2 years: _____ Dates:_____

Has this client received a Psychiatric Evaluation?: ___ (If YES, attach copy of psychiatric evaluation).

Has this individual been prescribed medication?: ___ (If YES, attach latest medication sheet).

Participant Name: _____

Referent Name:_____ **Title:**_____

Agency:_____ **Location of Office:**_____

Referent Phone #:_____ **License #**_____

Current Clinical Treatment Provider:_____

Psychiatrist:_____ **Clinician:**_____

How often is client seen at your agency:_____

Date last seen:_____

Is the client consistent with appointments:_____

Is the client aware that they are being referred to PROS:_____

Are they willing to participate in the PROS Program:_____

Care Manager Name & Agency:_____

Primary Care Physician: _____

REASON FOR REFERRAL

(Please be thorough in describing the needs and strengths of the participant)

AREAS OF NEED FOR PROS

____Employment ____Benefits and Finances ____Daily Living Skills

____Wellness and Self-Management ___Supports ___Social (Community Living)

____ Recreational ____Clinical Services(Medication/Therapy) ___ Educational

Please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

Please List Participant's Strengths:

_____

_____

_____

_____

Guidelines for Referrals

The following information is needed to processes ALL referrals to PROS:

- Fully completed referral form
- Current Psychiatric Evaluation
- Health Screening
- Current Psychosocial
- Most recent treatment plan
- Consent form
- Latest medication sheet (If clinical referral or transfer of clinics, **MUST** have a 30 day supply of medications)
- Current Assisted Outpatient Treatment/Enhanced Services Package

If any of the above is not available, Please explain:

_____

_____

_____

_____

_____

To be completed by PROS Administration Only

Will the participant be screened by the program: ____Yes ____No*

Intake Date & Time: _____ Screener: _____

*Justification for not screening participant at the PROS program:

_____