Referral Form Community Care Management
253 Mansion St. Poughkeepsie, NY 12601
Phone#: 845-473-2500 Fax#: 845-471-6932 for referrals

Supporting Documents Needed to Accompany Referral

****Please complete the checklist before submitting referral**

_ HIPAA Consent to Release Information form signed by Client

_ Current Evaluations and Assessments

_ Current Medical/Psyciatric information & history

_ Current Mental Health Status & History

_ Medications

_ Discharge Planning (if applicable)

_ Flaggings (if applicable, ie. info concerning suicidal ideations/attempts; homicidal ideations/attempts; allergies)

_ Other relevant information

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Client Name:_________________________ Medicaid#_________________ DOB:____________ Date:_____________
Address: ____ SS#:_________________
Home Phone:_______________ Cell Phone:_______________ Reg#:_______________ Email:___________________

CLIENT MUST MEET ONE OF THE BELOW CRITERIA

Client's Psychiatric Diagnosis	**Client's Chronic Medical Conditions** (must have 2 chronic medical conditions)	**Alcohol and/or Substance Abuse**
Axis I ____________________	______________________________	Last time used:____________________
Axis II ____________________	______________________________	# times in treatment:_______________
Axis III ____________________	______________________________	Type of substance(s) used:__________
Axis IV ____________________	______________________________	__________________________________

Medications Client is currently taking:____
____

Date(s) of last hospitalization and indicate reason:____
____

Name of Referent:_______________________ Hospital:___________________ Phone#:______________________

Referent Title:__________________________ Date of last visit: ________________ #times seen:_________________

Has client ever been charged or convicted of a violent crime, please describe:____

Does client have a history of suicidal ideations/attempts, please describe:____

Please check off areas of need client wants to work on:
_____Medical _____Vocational/Educational _____Housing _____Budgeting money _____Access to resources
_____Other area(s) to work on, please describe:____

Name of Psychiatrist/prescriber:________________________ Agency:_____________________ Phone:_______________
Name of Primary Care Physician:________________________ Practice:____________________ Phone:_______________

Indicate if client can only work with a male or female:____
Best time of day to reach client:____________________ Emergency Contact:__________________________________
Relationship of Emergency Contact:_________________ Cell#:______________________ Home#:___________________

Describe, in detail, the reason for Referral:

To be completed by Care Management Administration Only

Admission / Non-Admission

Will client be accepted: Yes:____ No:____ Explain why:____

Date Assigned:___________Care Manager Assigned:____