Referral to Wallace H. Johnson Group Home

Referral Source:		Date:	
Contact Name:		Phone/Fax:	

Description of Person Being Referred

Referral Name:		Gender:		Date of birth:	
Age:		Marital Status:	☐Single ☐Married ☐Divorced	Insurance Type:	
Insurance ID number:		Income source:		Monthly amount:	
Education Level:	☐Some HS ☐HS Grad/GED ☐Some college ☐Trade school ☐Associates degree				
☐Bachelor's degree ☐Master's degree ☐Other:					
Employment Status:	☐Unable to work ☐Student/Homemaker ☐Part time ☐Full time ☐Retired ☐Unemployed				
Living Situation:	☐Independent ☐With Family ☐Group Home ☐Hospital ☐Other:				
Legal Issues:	☐No ☐Yes	If yes, describe:			
Children:	☐No ☐Yes	If Yes #			

Describe Presenting Problem of Person Being Referred

Precipitating events:	
Current psychiatric symptoms:	
Length of time symptoms have been present:	
Impact of symptoms of functioning:	
Interventions that have improved functioning in the past:	

Describe Crisis/Safety Issues

History of suicidal Ideation:	☐No ☐Yes	If yes, describe:	
History of suicide attempts:	☐No ☐Yes	If yes, describe:	

History of self-injurious behavior:	☐No ☐Yes	If yes, describe:	
History of Harming others:	☐No ☐Yes	If yes, describe:	

Describe the Strengths of the Person Being Referred (include skills and hobbies)

When was this person last employed?		What type of job did they have?	

Current Psychiatric Diagnosis

Current Substance Use

Summary of Substance Use History (type of substance, length of use)

Summary of Psychiatric History (include levels of care, dates, length of stay)

Medical Information

Height:		Weight:		Medical conditions:	☐TB ☐Hypertension ☐Diabetes ☐Asthma

☐TBI ☐Epilepsy ☐Sleep Apnea ☐Pregnancy ☐Obesity ☐COPD ☐Fall risk ☐Hearing impairment

☐Vision impairment ☐Recent surgery ☐Kidney disease ☐Liver disease ☐Cancer ☐Chronic pain

☐Allergies ☐Enuresis/encopresis ☐Requires oxygen ☐Other:

If yes to above conditions, describe impact on functioning:	
Ambulatory status:	
Dietary restrictions:	

Current medications:	
Recent history of taking medications as prescribed:	
Medication efficacy:	

Treatment Goals

In the words of the person being referred describe what they hope to accomplish:	
Skills that need to acquired:	
Case management needs:	

Person being referred currently has:	Birth certificate ☐No ☐Yes	Driver's license ☐No ☐Yes
Other comments/information:		

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Signature of person completing form Title