CROSSROADS COMMUNITY, INC.
CASE MANAGEMENT REFERRAL FORM

Send Case Management Referrals to: **Crossroads Community Case Management Program Coordinator** **P.O. Box 718** **Centreville, MD 21617** Phone: 410-758-3050, ext. 44 FAX: 410-758-1223
Please Include the Following if Available: **ITP** Psycho-Social History Psychiatric Evaluation **For CCI use only** **GCM_____** **TCM_____**

CONSUMER INFORMATION

Name_____ DOB_____ Gender: M F

Address_____

Town:_____ County_____ State_____ Zip Code_____

Phone_____ Cell Phone _____ Work Phone #_____

Legal Guardian (if applicable):_____

Guardian Address (if different from above): _____

Town:_____ County_____ State_____ Zip Code_____

Phone_____ Cell Phone _____ Work Phone #_____

Ethnicity:

- ☐ African American
- ☐ Hispanic
- ☐ Biracial
- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Asian American/Pacific Islander
- ☐ Other (explain)

MA or Gray Zone # _____ SS#_____

Pharmacy Assistance #_____

FINANCIAL INFORMATION:

- ☐ SSDI Amount_____
- ☐ SSI Amount_____
- ☐ Employed Employer:_____

  Job Title:_____ Wages_____/_____

Please provide additional information about employment history: _____

_____

Current School/College_____ Special Ed Student? Y N

Grade/YR:_____ H S Graduate? Y N College? Y N

Please provide additional information about Education history:_____

_____

_____

REFERRAL SOURCE

Name_____ Referral Date_____

Agency_____

Address_____

Phone _____ Fax _____

.

CURRENT DSM-IV-TR DIAGNOSIS

Axis I:_____ DSM-IV Code:_____

Axis II:_____ DSM-IV Code:_____

Axis III:_____ DSM-IV Code:_____

Axis IV:_____ DSM-IV Code:_____

Axis V: Current GAF: _____ Date:_____

Highest GAF in last year:_____ Date:_____

The following eligibility criteria must be met in order to receive
Mental Health Case Management Services.

Eligibility Criteria

Priority for services shall be given to individuals who meet the criteria for Priority Populations listed below and who:

A. Are not linked to mental health services
B. Lack basic supports for shelter, food, and income, or,
C. Are transitioning from one level of care to another.

Priority Populations:

A) Children and adolescents with serious emotional disturbance who are in or at risk of:
   i) Inpatient psychiatric treatment
   ii) Treatment in a Residential Treatment Center (RTC), or,
   iii) An out of home placement due to multiple life stressors

OR

B) Adults with a serious mental illness who are:
   i) At risk of going into, or will be released from, an inpatient hospital stay
   ii) homeless or in Shelter Plus Care,
   iii)Residing in independent housing and in need of services to retain their housing, or,
   iv) Being released from a detention center

SERVICE PROVIDERS

Primary Somatic Health Care Provider:

Name:_____ Phone _____

Address:_____

Primary Therapist (Mental Healthcare/Clinical): Agency:_____

Name:_____ Phone:_____

Address:_____

CURRENT MEDICATIONS

Rx_____ Dosage_____

Rx_____ Dosage_____

Rx_____ Dosage_____

Rx_____ Dosage_____

Rx_____ Dosage_____

Rx_____ Dosage_____

HOSPITALIZATION OR PLACEMENT HISTORY: (Include RTC, group homes, foster, hospitalization, jail)

How many years has this client received mental health services? _____

Currently inpatient or incarcerated? ☐ Yes ☐ No If Yes, Projected D/C Date:_____

If inpatient, does this patient currently have off-grounds privileges without staff? ☐ Yes ☐ No

Hospital/Prog:_____ Dates: _____

Hospital/Prog:_____ Dates: _____

Hospital/Prog:_____ Dates: _____

Hospital/Prog:_____ Dates: _____

Allergies or Reactions to Medications:_____

_____

Dietary Restrictions:_____

_____

EMERGENCY CONTACT (If other than Legal Guardian) (Required for Consumers under 16):

Name:_____ Relationship:_____ Phone:_____

Address:_____

OTHER AGENCY INVOLVEMENT

☐ DDA ☐ DSS ☐ DJS ☐ Family Support Center

☐ Other:_____

What need prompted this referral now? _____

_____

RISK BEHAVIOR & PRESENTING PROBLEMS

Behavior/Problem (if current, the problem MUST be explained)	**Current**	**History**
Suicidal/Homicidal Threat/Attempt (give date of most recent occurrence) Explain:		
Chronic Health Problems/Medical/Somatic/Physical Impairment or Disability Explain:		
Substance Abuse Explain:		
Learning Difficulties/School or Vocational Problems Explain:		
Legal Issues (charges, delinquent behavior, probation, etc) Explain, if COR:		
Runaway Behavior Explain:		
Malicious Destruction of Property Explain:		
Sexual Issues (aggressor, promiscuous) Explain:		
Abuse/Assault/Trauma Victim Explain:		
Chronic Anger/Aggression (physically, verbally, weapon involved etc.) Explain:		
Social Interpersonal Conflicts Explain:		
Family Problems/Peer Conflicts Explain:		
Coping With Daily Roles & Activities Explain:		
Depression/Mood Disorder Explain:		
Eating Disorder Explain:		

Thought Disorder Explain:		
Other (e.g. fire starter, self mutilation, hallucinations) Explain:		

What services or additional linkages does the client need at this time? (Circle all that apply)

Family:	Respite	Family Therapy	Other (explain)	
Psychological:	Therapist	Psychiatrist	PRP	Group Therapy
	Substance Abuse Tx	Neuropsychological	Other	
Housing:	Section 8	Subsidized Housing	ER	Shelter
	Other (explain)			
Medical:	Primary Care Doctor	Dentist	Pain Clinic	Other (explain)
Education:	School Advocate	GED Program	School Assessment	School Meeting
	Other (explain)			
Employment/Vocational:	Supported Employment	Other (explain)		
Transportation:	Public Transportation	Other (explain)		
Financial/Entitlements:	Medical Assistance	MA Buy-In Prog.	SSI/SSDI	DEAP
	TCA/TEHMA	Food Stamps	Other (explain)	

CONSUMER REFERRAL AGREEMENT

I (guardian/self) _____ agree to the referral for Case Management services from Crossroads Community, Inc.

I authorize _____ (referral source) to release/exchange information to Crossroads Community, Inc. for the purpose of facilitating the disposition of the referral. I understand that the information exchanged may include the diagnosis, evaluations and records of progress.

I understand that this authorization is valid for one year from the date of signing, and that I may retract it in writing at any time.

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____