

Bridgeway Rehabilitation Services
93 Stickles Pond Road
Newton, NJ 07860



Fax # : 973-383-8676
Phone #: 973-383-8670

REFERRAL FORM
COMMUNITY SUPPORT TEAM, SUSSEX

Referral Date: _____ Referred By (Name/Agency): _____

Name: _____	D.O.B. : _____
Address: _____	Social Security #: _____
_____	Cell Phone #: _____
_____	Home Phone #: _____
Referring Contact Person: _____	Phone #: _____

Reason for referral? _____

Services Requested:
<input type="checkbox"/> Case Management: <input type="checkbox"/> ICMS: Recently discharged from state/county/voluntary psychiatric hospital and needs assistance to link to community services.
or
<input type="checkbox"/> PATH: Homeless or at risk of homelessness and diagnosed with a psychiatric illness; in need of assistance to secure housing and other services
or
<input type="checkbox"/> SUPPORTED HOUSING: Involved with mental health treatment and in need of additional support to maintain housing; linkages to services.
<input type="checkbox"/> Partial Care: 3 to 5 day programming. Illness management and skill development.
<input type="checkbox"/> Supported Employment: Support to choose, get, keep and leave competitive employment.
Comments: _____

Income Source: _____
Insurance: _____
Medicaid #: _____ Medicare #: _____
Other: _____ ID #: _____

RECORDS MUST BE INCLUDED WITH REFERRAL
(i.e., Intake Assessment, Treatment Plan, Psychiatric Evaluation, Discharge Summary)
Mail or fax to the attention of Joe Zvirblis, PHD

Diagnoses/Codes

Psychiatric: _____

Medical: _____

Current Medications (dosage & frequency): _____

Treatment

Current Psychiatrist/APN: _____ Phone#: _____ Therapist: _____

Community Supports: _____ Phone #: _____

Psychiatric Hospitalizations (includes dates): _____

Medical Issues: _____

Alcohol or Substance Abuse: ____ Yes ____ No Treatment Hx: _____

History of assault/violence: _____

Legal Involvement: _____

History of suicidality: _____

Family involvement: _____

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**For Bridgeway Use Only:  
Identified Service Requests:**

Date Received: \_\_\_\_\_ Intake Engagement Specialist: \_\_\_\_\_

Person Contacted: \_\_\_\_ Yes \_\_\_\_ No Dates \_\_\_\_\_

Intake Date & Time: \_\_\_\_\_ Service: ICMS PATH SH PC SE

Immediate Needs \_\_\_\_\_

Disposition/follow-up /plan for immediate needs \_\_\_\_\_

Signature \_\_\_\_\_

Does not meet criteria for services (Circle all that apply) ICMS PATH PC OPAL SE

Follow up/referrals \_\_\_\_\_

Signature \_\_\_\_\_ Reviewed by (signature): \_\_\_\_\_

Title: \_\_\_\_\_