Bridgeway Rehabilitation Services
Referral Form

Complete this Form and Fax To:	Elizabeth PACT (908) 352-6920 Plainfield PACT (908) 791-0512 Union PACT (908) 688-5377 Hunterdon/Warren PACT (908) 835-8650 Hudson PACT (201) 653-5049 Somerset PACT (908) 595-1921	Passaic PACT Team 7 (973) 638-1126 Passaic PACT Team 8 (973) 638-1119 Bergen PACT Team 9 (201) 880-8326 Homeless Outreach (908) 249-4106 Supported Housing Union (908) 249-4106 Supported Housing Hunterdon (908) 237-2577 Partial Care (908) 355-8853

REFERRAL SOURCE INFORMATION

Today's Date:		**Referring Agency is: (check if applicable)**			
Referring Persons Name:			**STATE**		**PH/PC**
Referring Agency Name:			**VNA**		**STCF**
Phone #:			**ICMS**		**IPU**
Fax #:			**PACT**		**ER**

DEMOGRAPHIC INFORMATION

Person Served Name:		**SS#:**	
Address:		**Date of Birth:**	
		Phone#:	
Religious Preference:		**DSM IV Code Axis I:**	
Gender:	_______ Male ________ Female	**DSM IV Code Axis II:**	
Ethnicity:	_______ Asian _______ Black ______ Other _______Hispanic _______ White	**IPU Admission Date:**	
Emergency Contact Name:			
Address:		**Phone#:**	

BENEFIT AND INSURANCE INFORMATION (Source and amount of Monthly Income)

Medicaid # ________________ Medicare #____________________ PAAD #_________________ Private Insurance________________

SSI $_____________________ SSD $ ________________________ Welfare $_______________ Salary $_______________________

Pension / VA $______________ Other $________________________ None __________________ Unknown _____________________

Payee Name:		
Address:		Phone#:
Criminal Record/ Current Legal Status:		

SERVICE NEEDS / ELIGIBILITY CRITERIA Check all that apply in desired program.
Must be a resident of the county for which you are applying and have a primary diagnosis of a major psychiatric disorder

Partial Care:	___ Employment Services ___ Independent Living Skills ___ Socialization ___ MICA Services ___Stabilization / Structure ___ Mental Health Education ___ Supportive Counseling

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	___ Homeless ___ Single Adult ___ Referral and Linkage
Supportive Housing:	___ Individual wants permanent affordable housing ___ Individual wants to live independently with supports ___ Individual is living in a residential program and is ready to graduate to independent living ___ Individual is capable of taking care of some basic living skills but needs some support in some areas ___ Individual has some insight into his/her mental illness and is motivated to work on independent living goals
PACT Team Services	___ Serious & persistent mental illness of at least 12 months duration ___ Demonstrated lack of benefit from refusal to participate in intensive ambulatory or residential mental health services for a duration of at least six months. **Hospitalization history within past 18 months (must meet one of the following):** ___ Two or more State Hospitalizations ___ One State Hospitalization with one or more other psychiatric hospitalizations ___ One State Hospitalization with multiple screening center episodes ___Two or more STCF and/or County Hospital admissions ___One STCF or County Hospital Admission with one or more other psychiatric hospital admissions/or multiple screening center episodes ___Two or more involuntary psychiatric hospital admissions at private psychiatric hospital
IPU Dates for past 18 months:	

PRESENTING PROBLEMS (Check all that apply)

___Alcohol Abuse	___ Drug Abuse	___ Organic Mental Disorder
___ Anxiety	___ Eating Disorder	___ Physical Neglect
___ Assaultive Behavior / Threat	___ Economic Stress	___ Runaway Behavior
___ Bizarre Behavior	___ Fire Setting / Ideation	___ Sexual Abuse/ Rape Victim
___ Daily Living Problems	___ Homicidal Behavior / Threat	___ Sexual Abuser
___ Depression/ Mood Disorder	___ Legal / Justice Involvement	___ Social / Interpersonal
___ Destructive to Property	___ Marital/Family Problems	___ Suicide Attempt
___ Developmental Disability	___ Medical / Somatic Concerns	___ Suicide Threat
	___ No Social Support Resources	___ Thought Disorder
		___ Other:

PRESENT COMMUNITY TREATMENT PLAN (for Partial Care and/or Homeless Outreach referrals *only*)

Psychiatrist Name:	**Service Provider Name:**
Phone:	**Phone:**
Address:	**Address:**
Next Appointment:	**Next Appointment:**
Medical Treatment Plan:	

CURRENT MEDICATION (for all referrals)

Medication	Dosage	Frequency

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PSYCHIATRIC BACKGROUND INFORMATION **To be completed only if no psychiatric or medical records accompany the referral**
Psychiatric History:
Precipitating Factors for most recent Hospitalization:
Physical/ Medical conditions:
Substance Abuse History/Treatment:
Comments: (Please include a brief description of any significant impression or other relevant concerns)

FOR INTERNAL USE ONLY:

ACCEPTED: ________________ **DATE STARTED:** ____________

NOT ACCEPTED:____________ **REASON FOR NOT ACCEPTANCE**:

_____ Does not meet eligibility criteria ______ Substance Abuse only _____ Lost

_____ Refused program ______ Long term Hospitalization _____ Other

REFERRED TO:____