GLADE RUN LUTHERAN SERVICES
1008 7TH AVENUE
BEAVER FALLS, PA 15010
724-843-0816
724-843-0818 (FAX)

BLENDED CASE MANAGEMENT
REFERRAL FORM
PLEASE FAX REFERRAL AND EVALUATION TO 724-843-0818

CLIENT NAME: _____

REFERRAL DATE: _____ DOB: _____ AGE: _____

MA # _____ SSN: _____

INS: _____ GENDER: _____ RACE: _____

REASON FOR REFERRAL: _____

_____

_____

_____

_____

REFERRAL SOURCE: _____

WORKER: _____ REFERRING COUNTY: _____

PATIENT INFORMATION

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE NUMBER: _____

PARENT / LEGAL GUARDIAN INFORMATION

NAME: _____ NAME: _____

RELATIONSHIP: _____ RELATIONSHIP: _____

ADDRESS: _____ ADDRESS: _____

CITY: _____ CITY: _____

STATE: _____ ZIP: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ PHONE NUMBER: _____

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DIAGNOSIS

CLINICAL SYNDROMES (AXIS I):

PERSONALITY DISORDERS / INTELLECTUAL DISABILITES (AXIS II):

MEDICAL CONDITIONS (AXIS III):

STRESSORS (AXIS IV): OVERALL FUNCTIONG:

- ☐ PRIMARY SUPPORT GROUP
- ☐ HOUSING
- ☐ SOCIAL ENVIRONMENT
- ☐ ECONOMIC
- ☐ EDUCATION
- ☐ ACCESS / HEALTH CARE
- ☐ JOB / OCCUPATION
- ☐ LEGAL / CRIME
- ☐ OTHER

GAF (AXIS V):

CURRENT GAF: _____ HIGHEST GAF LAST YEAR: _____

CURRENT MEDICATIONS: _____

_____

_____

_____

_____

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TREATMENT HISTORY

- ☐ SIX OR MORE DAYS OF PSYCHIATRIC INPATIENT TREATMENT IN THE LAST 12 MONTHS
- ☐ HAS MET THE STANDARDS FOR INVOLUNTARY TREATMENT IN THE LAST 12 MONTHS (ADULTS ONLY)
- ☐ CURRENTLY RECEIVING OR IN NEED OF MH AND RECEIVING OR IN NEED OF TWO OR MORE HUMAN SERVICE AGENCIES OR PUBLIC SYSTEM: _____
  _____
- ☐ AT LEAST 3 MISSED COMMUNITY MH APPOINTMENTS IN THE PAST 6 MONTHS (ADULTS ONLY) OR,
- ☐ 2 OR MORE FACE TO FACE ENCOUNTERS WITH CRISIS OR EMERGENCY SERVICES IN THE PAST 12 MONTHS (ADULTS ONLY) OR,
- ☐ DOCUMENTATION THAT THE CONSUMER HAS NOT MAINTAINED MEDICATION REGIME FOR 30 DAYS

FUNTIONING LEVEL: (CHECK AT LEAST ONE)

- ☐ GAF SCALE RATING OF 60 OR BELOW FOR ADULTS, 70 OR BELOW FOR CHILDREN
- ☐ INDIVIDUALS RECEIVING ICM / RC / BCM SERVICES AS CHILDREN AND RECOMMENDED AND APPROVED FOR CONTINUED SERVICES

CURRENT AGENCY INVOLVEMENT

	AGENCY NAME	CONTACT	PHONE #
☐ LTSR			
☐ CCR			
☐ OP			
☐ CATHOLIC CHARITIES			
☐ MH / MR			
☐ BHRS			
☐ PUBLIC ASSISTANCE			
☐ D / A			
☐ SOCIAL SECURITY			
☐ VOC REHAB			
☐ MHA			
☐ ADULT / JPO			
☐ HUD			
☐ VOICE			
☐ LITEHOUSE			
☐ OTHER			

SERVICES NEEDED (IF CHECKED PLEASE BE SPECIFIC)

- ☐ INCOME: _____
- ☐ CONNECTING TO SOCIAL SERVICES: _____
- ☐ D / A ISSUES: _____
- ☐ EMPLOYMENT: _____
- ☐ EXPAND SOCIAL SUPPORT SYSTEM: _____
- ☐ HOUSING: _____
- ☐ BENEFITS (SS, SSI, FOOD STAMPS, MA…): _____
- ☐ LACK OF FAMILY INVOLVEMENT: _____
- ☐ MEDICAL: _____
- ☐ MH ISSUES: _____
- ☐ EDUCATIONAL CONCERNS: _____
- ☐ ATTENTION TO ADLs: _____
- ☐ OTHER: _____

PLEASE FAX WITH CLIENT PSYCH EVALUATION TO 724-843-0818