



**TRAIME BEHAVIORAL HEALTH, INC.
REFERRAL SCREENING FORM**

Date of Referral: _____

Name of Person Making Referral _____

Consumer Informed of Referral? ☐ Yes ☐ No

Demographic Information

Consumer Name: _____ Address: _____

Date of Birth: _____

Telephone #: _____ S.S.#: _____

Gender: M _____ F _____ Race: _____

Marital Status [M] _____ [D] _____ [W] _____ [S] _____ [Separated] _____

Consumer Lives With: _____

Financial Resource: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ None

☐ Social Security Amount _____ ☐ SSDI Amount _____

☐ Retirement Amount _____ Payee Name: _____

☐ Veteran's Administration Benefits

Emergency Information

Emergency Contact: _____ Relationship: _____

Telephone #: _____

Referral Source Information

Referred By: _____ Organization/Agency: _____

Other Agencies/Family Involved: _____

Address: _____

Telephone #: (Mandatory) _____ Fax #: _____

****Email Address (Person Making Referral)** _____

Reason for Referral: (**Note: Housing Only Must Provide DLA*)

Immediate/Urgent Needs _____

Strengths/Skills/Abilities: _____

Mental Health Information
Please check all that apply

Hospital Admissions [] 3 times in last 12 mos. [] 2 times last 6 mos [] 60 consecutive days

Name of Hospitals and Hospitalization Admit and Discharge Dates:

Reason for Hospitalization: _____

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Emergency Room Visits and Dates: _____

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Psychiatric Diagnosis:

Current Medication(s): *(Please include dosage)*

1. _____ 3. _____

2. _____ 4. _____

PHYSICIAN (S): _____

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Legal History Information:

Status: [] Forensic Conditional Release [] Outpatient Commitment [] Expiration Date: _____

List Criminal Offenses and Dates _____

Hearings/Trials Pending and Dates _____

--

Probation/Parole Officer Name: _____ Phone #: _____

Danger to Self/Others: [] Violence Towards Self [] Violence Towards Others [] Violence

Towards Property [] Sexual Assault [] Fire Setting [] Non-medication compliance

Describe (Legal Continued):

Check All That Apply:

Difficulty with the Following:

- ☐ Finances ☐ Executing Personal Care Skills ☐ Transportation ☐ Family Relationships
☐ School/Vocational ☐ Interpersonal Skills ☐ Social, leisure activities ☐ Household Tasks

Describe Relationship with Family:

****A check mark below indicates that consumer, referring professional, and family are in agreement with referral:***

- ☐ Consumer agrees with referral to Traime, Inc.
☐ Consumer Family Member(s) agree with referral to Traime, Inc.
☐ Psychiatrist agrees with referral to Traime, Inc.
☐ Referring professional agrees with referral to Traime, Inc.
☐ Consumer being served by another agency/organization

Name Agency/Organization

Consumer's Signature/Date

Therapist/Clinician Signature/Date

AGENCY USE ONLY

Disposition:

Team Assigned To: _____ Date: _____

Status:

- ☐ Accepted Enrollment Date _____
☐ Pending Reason _____
☐ Denied Reason _____
☐ Waiting list Reason _____