No Longer Alone Ministries
REACH: Mobile Psychiatric Rehab Program
REFERRAL FORM

Consumer Name: _____

Address: _____

_____

Phone: _____

D.O.B: _____

S.S. #: _____

Psychiatrist: _____

Phone: _____

Case Manager: _____

Phone: _____

Family Physician: _____

Phone: _____

Other Provider:_____

Phone: _____

History of Aggressive Behaviors

No ☐ Yes ☐ Explain:

_____

Suicidal/Homicidal Ideation

No ☐ Yes ☐ Explain:

_____

Substance Abuse

No ☐ Yes ☐ Explain:

_____

Legal Issues:

No ☐ Yes ☐ Explain:

_____

Physical Illness/Limitations

No ☐ Yes ☐ Explain:

_____

Other Comments:

Date of Referral: _____

Referral Source: _____

Phone: _____ Fax: _____

Reason for Referral:

_____

_____

Strengths:

_____

_____

Diagnosis:

_____

_____

_____

_____

Medication:

_____

_____

_____

_____

Most recent Hospitalization:

Place: _____

Date: _____

Re: _____

Completed by:

_____

Please attach most recent Psychiatric Evaluation and Release of Information Form.

Return to Ann King-Grosh at aking-grosh@nlam.org or fax to (717) 390-4894

For Office Use Only

_____ Referral Received

_____ Intake Scheduled

_____ Outcome