NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH
Community Based Services Referral Form

SERVICE BEING REQUESTED			
◯ Crisis Services Coordination	◯ Forensic Case Management	◯ Hospital Diversion	◯ Partnership for Healthy Aging

CLIENT INFORMATION		
Name *(Last, First, M.I.):*	**Sex**: ◯ M ◯ F	**DOB:**
Address:	**Marital status:** ◯ Single ◯ Partnered ◯ Married ◯ Separated ◯ Divorced ◯ Widowed	**Phone** (H):
City:		**Phone** (M):
State:		**Phone** (O):
Zip:		**SSN:**
Lives Alone: ◯ Yes ◯ No	**If No**, Other in the home:	
Animals in the home:	**Weapons in the home:**	
Primary Insurance:	**Secondary Insurance:**	
Primary Insurance ID:	**Secondary Insurance ID:**	

REFERRAL SOURCE	
Person Making Referral:	**Today's Date:**
Agency:	**Telephone #:**

REASON FOR REFERRAL
Presenting Problem:

PREVIOUS INCARCERATIONS/REASONS:

MEDICAL HISTORY			
Mental Health Diagnosis:		**Initial Onset:**	
Substance Abuse:		**Medical Problems:**	
PMD – Primary Medical Doctor:			

HISTORY OF PREVIOUS TREATMENT

Inpatient Treatment

Inpatient Setting:	Dates:	Reason:	Outcome:

Outpatient Treatment

Clinician:	Dates:	Reason:	Outcome:

Copy enclosed/ Faxed to 716-278-8130. Attention: Hospital Diversion Program Supervisor

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MEDICATIONS				
Medication:	**M.D. Monitoring**	**Side Effects:**	**Side Effect Severity**	**Note:**

CURRENT LINKAGES/SERVICES				
	Telephone:	Ext.		
Agency:			Court System:	
Therapist:			Attorney:	Telephone:
Psychiatrist:			Parole:	
Care Manager:			Probation:	
SNAP: ◯ Yes ◯ No			Task:	
HEAP: ◯ Yes ◯ No			Mental Health Court:	
Medicaid: ◯ Yes ◯ No	Medicaid ID:		SPOA: ◯ Yes ◯ No	Date App. Comp.
Medicare: ◯ Yes ◯ No				
SSI/SSDI: ◯ Yes ◯ No				

Additional Needs to be Addressed:

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