CTT Web REFERRAL FORM

CHESTNUT RIDGE COUNSELING SERVICES, INC.
Fax 724-437-1875

Name ____________________________
DOB ________________ **Age** _____
Address __________________________ **Gender** __________________________
Ethnic Origin _____________________
Marital Status ____________________
Phone No. ________________________ **Education** _______________________
Occupation _______________________ **Income** __________________________
SSN _____________________________ **Insurance**_________________________
Case Manager ____________________
Ins. No. __________________________

Reason for Referral ____
____
____
____
____
****

Diagnosis: Axis I ____
Axis II ____
Axis III ____
Axis IV ____
Axis V ____

Current Medications:
____
____
____
____

Current Treatment:
Facility __________________________
Dr. ______________________________
Therapist/Social worker ___________
____

Significant Medical Conditions ____
____
Substance Abuse Issues ____
Legal Issues ____

Family/Support Individuals ____
Other Agency Involvement ____
****

Referral Source ____
Phone No. __________________________ Date ____________________________

Treatment/Social History (Check all that apply):
_____ 2 or more acute psychiatric hospitalizations within the past year
_____ 30 days or more of a psychiatric hospitalization within the past year
_____ 3 or more face-to-face crisis/emergency contacts within the past year
_____Homeless, as defined by sleeping in shelters or places not meant for human habitation or at-risk for repeated evictions or loss of housing
_____ Placed on probation, parole or in a jail diversion program within the past 6 months or at-risk for involvement with the criminal justice system
_____ A co-existing substance abuse disorder of more than 6 months
_____ History of inability to participate in traditional office-based services despite documented efforts to engage the individual by a recognized mental health professional or case management provider, as evidenced by
( ) at least 3 missed mental health appointments within the past 6 months
( ) documentation that the individual has not followed prescribed medication regime
( ) history of court ordered treatment
( ) documentation that the individual has not benefited from ICM services

Functional/Service Needs (Check all that apply):
_____ Basic self-care skills, activities of daily living
_____ Symptom/illness management
_____ Housing/household maintenance
_____ Social/ interpersonal/ leisure/ recreational
_____ Family education and support
_____ Substance abuse management
_____ Educational/ vocational support
_____ Financial management
_____ Legal support
_____ Other ________________________________

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The individual is interested in and chooses to receive CTT services at this time.
Yes __________ No _______________

Consumer's
Signature____
Date: ________________

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Admission Committee Review Date: ____________________________

Status:________ Accepted. _____

Dr's Signature____

________ Not Accepted.
Reason ____
____
____
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