Chautauqua County Department of Mental Hygiene
Single of Point Access (ADULT SERVICES)
Referral Form

PLEASE COMPLETE ENTIRE FORM AND ATTACH A COPY OF A RECENT PSYCHOSOCIAL EXAM, ANY AVAILABLE ASSESSMENTS OR MENTAL STATUS EXAM.

1. REFERRAL INFORMATION

Referral is for: ☐ Lake Shore Behavioral Health ACT/Strive Program
(Managed Care clients need ACT level of service determination of care)
Insurance Contact Name: _____ Phone #_____
☐ STEL ☐ COI ☐ ROME

Client Name: Gender: ☐ M ☐ F	Date of Referral:
Client Street Address: City/State/Zip:	Referring Agency and Address:
Client Phone Number:	
Client SSN: Client DOB:	Referral Contact Telephone #:
Client Medicaid # (include Sequence #) _____Seq._____ Private Insurance Name and Policy #_____	Referring Person:
EMERGENCY CONTACT, ADDRESS & PHONE #:	Alternate Contact, Address and/or Phone # for Client

Primary Referral Organization Affiliation:

☐ Mental Health Outpatient
☐ Local MH Practitioner
☐ Mental Health Residential
☐ State Psychiatric Ctr (inpt)
☐ CSP Mental Health Program
☐ Emergency Non-residential Program
☐ Other (specify) _____

☐ General Hospital ER
☐ General Hospital (inpt)
☐ MR/DD Facility
☐ Substance Abuse Program
☐ Other Medical Provider
☐ Social Services

☐ Family Court
☐ Criminal Court
☐ Probation/parole
☐ Jail
☐ Shelter for the homeless
☐ Self, family, friend

Reason for Referral: _____

_____

_____

2. PERSONAL & DEMOGRAPHIC INFORMATION

Race/Ethnicity:

☐ 1. White, Non-Hispanic
☐ 2. Black, Non-Hispanic
☐ 3. Hispanic
☐ 4. Asian
☐ 5. American Indian or Native
☐ 6. Other (specify)_____

Primary Language

☐ 1. English
☐ 2. Spanish
☐ 3. American Sign Language
☐ 4. Other_____

English Proficiency
(if primary language is other than English)

☐ 1. Does not speak English
☐ 2. Poor
☐ 3. Fair

Additional Information/Comments: _____

_____

_____

_____

REFERRAL INFORMATION **SPOA- Adult PAGE TWO**	NAME: Last First MI

3. LIVING ENVIRONMENT/ SUPPORT SYSTEM

Current Marital Status

- ☐ Single, never married
- ☐ Currently married
- ☐ Cohabiting with significant other/domestic partner
- ☐ Divorced/separated
- ☐ Widowed

Custody Status of Children

- ☐ No children
- ☐ Have children all > 18yrs.old
- ☐ Minor children currently in client's custody
- ☐ Minor children not in client's custody but have access
- ☐ Minor children not in client's custody-no access

Living Situation at Time of Referral:

- ☐ Lives alone
- ☐ Lives with spouse
- ☐ Lives with parents
- ☐ Lives with other relatives
- ☐ Assisted /supported living (specify) _____
- ☐ Nursing home/medical setting (specify) _____
- ☐ Supervised Apartment Program (specify) _____
- ☐ Supervised group home (specify) _____
- ☐ Psychiatric hospital (specify) _____
- ☐ Correctional setting (specify) _____

IS THERE ANY ADULT HISTORY OF HOMELESSNESS? ☐ ***Yes*** ☐ ***No***

4. EDUCATION & EMPLOYMENT VOCATIONAL STATUS

Current Education Level

- ☐ No formal education
- ☐ Some grade school (1-8th grade)
- ☐ Completed grade school
- ☐ Some HS (9-12th grade, but no diploma)
- ☐ HS diploma or GED
- ☐ Vocational, business training
- ☐ Some college, no degree
- ☐ College degree
- ☐ Masters degree
- ☐ Other:_____

Current Employment Status

- ☐ No employment
- ☐ Full-time
- ☐ Part-time
- ☐ Sheltered workshop
- ☐ Has job coach
- ☐ VESID involvement
- ☐ Other _____

Additional Information, Support Networks, Comments: _____

_____

_____

_____

REFERRAL NFORMATION **SPOA-Adult PAGE THREE**	NAME: Last First MI

5. ENTITLEMENTS & INCOME
(check all that apply)

Benefits or Insurance	Currently receives (Enter amount)	Pending - application submitted	Eligible - no application submitted	Ineligible	Unknown	Caseworker
Social Security						
SSI/SSD						
Public Assistance						
Veteran's Benefits						
Medicare/Medicaid (inc. #)						
Food Stamps						
Pension						
Wages/earned income						
Worker's Compensation						
Unemployment						
Private insurance (inc. #)						
Trust Fund						
Medication Grant						
Alimony						

Representative Payee

☐ Yes (Name): _____

☐ No

☐ Needs

Ability to budget money

☐ Independently

☐ Needs help

☐ Unable

☐ Unknown

6. PSYCHIATRIC INFORMATION

AXIS	*DESCRIPTION (include primary and secondary dx)*	*CODE*
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		

Current or last services *(check all that apply)*:

☐ **No prior service**

	HISTORIC	*CURRENT*	*LOCATION*	*DATES*	*CIRCUMSTANCES*
State Psych. Center (inpt)					
General Hospital					
Mental Health Residential					
Mental Health Outpatient					
CSP Mental Health Program					
Emergency Mental Health (non-residential)					
Prison, jail, court					
Local mental health practitioner					
Case management (specify type)					

REFERRAL NFORMATION SPOA-Adult PAGE FOUR	NAME: Last First MI

Current medications (psychiatric and medical) ***LIST ALL KNOWN ALLERGIES***

_____

_____

Prescribing doctor: _____

Number of psychiatric hospitalizations in past 12 months: _____

Number of psychiatric ER visits in the past 12 months: _____

Current case management/ACT ☐ No ☐ Yes, specify _____

Current AOT investigation/court order ☐ No ☐ Yes, specify _____

Compliance with treatment ☐ No ☐ Yes, specify _____

Compliance with medications ☐ No ☐ Yes, specify _____

7. LETHALITY/DANGEROUSNESS/ RISK FACTORS *(check all that apply)*

	History	Current	Date of most recent event	Dates of previous attempts	Method
Suicidal ideation					
Suicidal attempts					
Violence to others					
Arson					
Destruction of property					
Victim of abuse					
Perpetrator of abuse					

8. LEGAL
(Current Criminal Justice Status)

☐ None

☐ Released from jail/prison in last 30 days

☐ Currently incarcerated – prison

☐ Currently incarcerated-jail

☐ Other _____

☐ Alternative to incarceration (any voc. or addictions treatment)

☐ PPL 33.20

☐ Parole, Officer: _____ ph # _____-_____

☐ Probation, Officer: _____ph # _____-_____

Number of arrests in past 12 months: _____

Number of incarcerations in past 12 months: _____

REFERRAL INFORMATION **SPOA-Adult PAGE FIVE**	NAME: Last First MI

9. SUBSTANCE ABUSE HISTORY

☐ **None**

Drug **Frequency**

	Not in last month	Daily	1-2x/week	1-3x in the last month	3-6x/week
Any IV drug use					
Alcohol					
Marijuana/Cannabis					
Cocaine					
Crack					
Heroin/Opiates					
Hallucinogens					
Amphetamines					
PCP					
Sedative/hypnotic					
Benzodiazepines					
Prescription drugs					
Inhalants (sniffing glue, other household products)					
Other					

Longest period of sobriety: _____

History of chemical dependency treatment: ☐ **Yes** ☐ **No**

IF YES…

☐ Inpatient (specify where and dates) _____ # of treatment episodes _____

☐ Outpatient (specify where and dates) _____

10. MEDICAL

Functional medical problems (check all that apply)

☐ None
☐ Impaired ability to walk
☐ Requires special medical equipment
☐ Incontinent
☐ Hearing impairment
☐ Deaf
☐ Impaired vision
☐ Blind
☐ Other medical problem/condition: _____

_____

Primary Physician: _____

Address: _____Phone #: _____-_____

REFERRAL INFORMATION SPOA-Adult PAGE SIX	NAME: Last First MI

11. COMMUNITY SURVIVAL SKILLS

SKILL	INDEPENDENT (requires no assistance)	NEEDS HELP	UNABLE	REJECTS
ADL's (eating, hygiene, grooming, dressing, toileting)				
Personal safety (crossing streets, not getting lost, respond appropriately in an emergency)				
Use of public transportation and other community resources				
Plan, shop, prepare meals and clean				
Use/engagement with mental health services (taking medications, making appts, adherence to regimen/programs)				
Use/engagement in medical services (annual physical, and if applicable, taking meds, making appts, adherence to regimen, special diets, etc.)				
Social relationships (ability to establish or maintain satisfactory relationships with peers)				
Self-direction (impulse control, decision-making, judgment and value system)				

12. ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

13. SIGNATURE OF CLIENT:	Mail or fax completed referral and release to: **Single Point of Access** **Chautauqua County Mental Hygiene** **333 E. 5th Street, Jamestown, NY. 14701** **Phone: 716-661-8850 Fax: 716-753-9724**
Signature/Title/Agency of Person Completing Referral:	**Date:**

Chautauqua County Department of Mental Hygiene

OBTAINING AND RELEASING OF PSYCHIATRIC AND/OR SUBSTANCE ABUSE INFORMATION for SINGLE POINT OF ACCESS PROGRAM for ADULTS

Client Name: _____

Date of Birth: _____

Client consent form:

Single Point of Access Program For Adults is hereby granted permission to release and/or obtain information from my referral to and from the Committee Representatives of and/or Records Departments from: **the referral source, TLC (Lakeshore) Health Network and ACT Program, Buffalo Psychiatric Center Intensive Case Management, Lakeside Clinic, Waterfront State Operated Community Residence (SOCR); Chautauqua County Supportive Case Management, Outpatient Mental Health, SPOA Child Program, A.O.T. Program and Forensic Services; The Resource Center; DSS; Probation; Southern Tier Environments for Living (S.T.E.L.); Summit Community Services Continuing Day Treatment Program and Outpatient Clinics, WCA Hospital Inpatient and Outpatient Mental Health Programs, WCA Chemical Dependency, MH Substance Abuse, Chautauqua County Chemical Dependency Services (CCCDS), Mental Health Association and Housing Options Made Easy, Inc.**

OTHER: _____ EXCEPTIONS: _____
(to above)

I understand that information in my referral may contain information about my identity, diagnosis, treatment, prognosis, and may contain information about psychiatric and/or substance abuse diagnosis. I understand the only information disclosed will be pertinent and necessary to determine housing and case management needs. I further understand I have the right to attend the SPOA committee discussion regarding the appropriate level of care for my needs.

The purpose or need for disclosing and obtaining information is:

To allow the SPOA Committee to determine appropriate level of care and coordinate treatment.

I am not giving permission for any re-disclosure of this information other than specified above.

INSTRUCTIONS: Client or person acting for client **must** sign **A *and* B** to give permission for the release of information and to authorize permission for review by the SPOA Committee. **C is signed *only* when there is *denial* of permission.**

A. *My consent will expire when discharged from the SPOA Program* ***OR*** *on this date _____/_____/_____. I hereby grant permission for the exchange of information to the parties authorized. I also understand that I have the right to cancel my permission to release or obtain information at any time.*

Signature of client/person acting for client	Relationship	Date	Signature of Witness	Title	Date

B. *I hereby authorize the SPOA Committee review of my SPOA application and all relevant records obtained by the Single Point of Access Program, for the purpose of determining eligibility for services and level of care. I understand the Committee is comprised of representatives of various human service agencies in Chautauqua County, and that Committee members will hold all information in confidence.*

Signature of client/person acting for client	Relationship	Date	**Signature of Witness**	Title	Date

C. *I hereby refuse to authorize the release of information to the person/organizations, facilities, or programs above.*

Signature of client/person acting for client	Relationship	Date	Signature of Witness	Title	Date

Revised 2/10/2023