Side By Side Supported Living, Inc.
Clinician's Referral Form

FORM C

DATE: _____/_____/_____

Name of Physician: ____________________________ Phone #: __________________________

Address: ____

Length of contact: ______________ Location of contact: ___________________________

Applicant's name: ____

Address: ____

____

Phone number: ______________________________ D.O.B.: _____/_____/_____

SS#: _______/_____ /________

Martial Status: ☐ Married ☐ Single/Never married ☐ Separated

☐ Divorced ☐ Cohabitating ☐ Widowed

DSM-IV DIAGNOSIS:

AXIS I: ____

AXIS II: ____

AXIS III: ____

AXIS IV: ____

AXIS V: GAF _______________ (Current)

GAF _______________ (Highest level: ____w/in past year ____ever)

PSYCHIATRIC HISTORY

Current mental status: ____

____

____

History of treatment: ____

Applicant's Name: ______________________________ Date of Birth: ____________

____

____

Hospitalizations: ____

____

____

____

Does the applicant have a history of any of the following?

Suicidal/Homicidal Behavior? ☐ Yes ☐ No

Self-Mutilating Behavior? ☐ Yes ☐ No

Sexually Inappropriate Behavior? ☐ Yes ☐ No

Aggressive or Assaulting Behavior? ☐ Yes ☐ No

Substance Abuse? ☐Yes ☐ No

Date of last use: ____________________

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BELOW WITH DATES IF POSSIBLE

____

____

____

____

Current living situation: ☐ Alone ☐ Family ☐ OTHER (PLEASE EXPLAIN)

____

____

If the applicant is not his/her own guardian, please provide guardian's name, address, and phone and check the type of guardianship that applies:

☐ Person only ☐ Finance only ☐ Both

____

____

____

Does the applicant have any problems with incontinence? ☐ Yes ☐ No

*Is the applicant able to perform the following ADL'S:*** (IF NO, PLEASE DESCRIBE LIMITATIONS)***

Toilet self ☐ Yes ☐ No Bathing ☐ Yes ☐ No Brushing teeth ☐ Yes ☐ No

Dressing ☐ Yes ☐ No Feeding self ☐ Yes ☐ No Laundry ☐ Yes ☐ No

Applicant's Name: ______________________________________ Date of Birth: ____________

____

____

____

____

Has the applicant ever been arrested or been convicted of a crime? ☐ Yes ☐ No
*** (IF YES PLEASE EXPLAIN & PROVIDE DATES)

____

____

____

What are your goals for the applicant's involvement with SBS? ____________________

____

____

____

Suggested length of services: ☐ 3-6 MOS. ☐ 6-12 MOS. ☐ More than 12 MOS.

Medical history: (please attach records if applicable)

____

____

____

____

Sexual orientation: ____

Please list any communicable diseases: _____________________________________

Please list any STD's: ____

HT.: _______ WT.:_______ Date of last Tetanus: _____________ PPD:_____________

Has there ever been a head injury: ☐ Yes ☐ No

Has there ever been a history of seizures: ☐ Yes ☐ No

Major surgeries: ____

____

____

Limitations to physical activity: ____

____

____

Applicant's Name: ___________________________________ Date of Birth: ___________

Please list any allergies: ____

____

____

CURRENT MEDICATIONS:

MEDICATION	DOSE	ROUTE	SCHEDULE	DURATION	INDICATION

PRN MEDICATIONS:

MEDICATION	DOSE	ROUTE	INDICATION

Physician's signature: ____

Date: __________________

***** PLEASE SUBMIT THE LAST DIAGNOSTIC ASSESSMENT AS WELL AS A SIGNED RELEASE OF INFORMATION FORM FROM THE PATIENT *****