COMMUNITY FRIENDSHIP, INC.
85 Renaissance Parkway, N.E.
Atlanta, GA 30308
404-875-0381 (fax) 404-875-8248

REFERRAL FORM

Please answer the following questions as completely as possible:

Consumer Information

Name of Consumer:____________________ DOB:________ SS#:________________ SEX:______

What is the consumer's source and amount of income? Gen. Asst. $______ SSI $_______ SSDI $_______ Other $____ None_______

Medicaid # _______________ Medicare #____________

Where and with whom does the consumer live? ________________________

Street:____

City:_________________________ State:_______ ZIP:___ County:________ Phone #:_______________

Do they have a DBHDD Housing Voucher? ☐ Yes ☐No

Employment /Educational Information

What jobs/employment has the consumer had?

Job Title	Length of Employment From - To	Reason for Leaving

What is the consumer's educational background? Highest year completed Date______________________

Special/vocational training Yes___ No___ What____

Psychiatric Hospitalization/Mental Health Services

Has the consumer ever been hospitalized for psychiatric illness? __________ If yes, provide the following information:

1. Most Recent Hospitalization: Where:____

   Date Admitted:____________________ Date Discharged:__________________________

2. Previous Hospitalization

Hospital	City	Date	Contact Person

Is the consumer currently participating in outpatient psychiatric treatment?________

If yes, provide the following information:

Mental Health Center/Facility:____________________________________

Contact Person______________________ Telephone_______________ Email ______________________

**Primary DSM 5/ICD 10 code:_______________Diagnosis name:__________________________________

Please attach supporting documents of the diagnosis that are within the last 12 months of this referral: i.e. Diagnostic Assessment.

What services are being provided?_________________________________

What is the name and dosage of prescribed medications?____

****If the consumer is currently an in-patient, please answer the questions on medications and please indicate the mental health center that will provide outpatient services upon discharge.***

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Physician/Licensed Psychologist/LCSW/LPC or APRN Signature	Physician/Licensed Psychologist/LCSW/LPC or APRN Printed Name

Substance Abuse History

Does the consumer have a history of drug or alcohol abuse?_____

Has the consumer ever been hospitalized for drug or alcohol abuse? If yes, provide the following information:

1. Most Recent Hospitalization: Where:______________________

   Date Admitted: Date Discharged:______________________

   Primary DSM 5/ICD 10 code:__________ Diagnosis name:______________________________

Is the consumer currently participating in outpatient substance abuse treatment?

If yes, provide the following information:

Treatment Center____________________

Contact Person_______________ Telephone #______________ Email ________________________

How long in Treatment? __________________________________

Other Community Program Involvement

Is the consumer currently participating in or receiving benefits from other community programs? If yes, provide the following information:

Name of Program____________________ Telephone #______________________

Contact Person____________________ Email __________________________________

What services are being provided?____

Does consumer have a Rehabilitation Services Counselor? If yes, give name of counselor__________ Telephone___________

Does consumer have physical, medical problems, special diet, or allergies requiring special attention?

If yes, please describe____

What specific goals do you and the consumer expect to be achieved through participation at CFI? For VR clients, please indicated work goal.

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At present, what is the consumer's primary need? Please check ONE of the following services that would address this need. NOTE: referral to one department allows consumer access to other departments as needed.

☐ Homeless Outreach & PATH (Community Linkage, Entitlements, etc.)

☐ Housing(Group Homes & Supervised Apts)

We cannot accept applicants for Housing who have been evicted from federally-assisted housing within the last three years for drug-related criminal activity; a person who is subject to a state lifetime sex offender registration program (HUD properties only); a person who abuse or pattern of abuse of alcohol interferes with the health, safety, or right to peaceful enjoyment of the premises by other residents. We will ask applicants to comply with a criminal history check.

☐ Supportive Services at Phoenix House, O'Hern House, Rosalynn & Presley Woods (* Individuals must be a current resident of one of these properties).

☐ PSR Day Services(Work Adjustment, Vocational Evaluation, Day Services, Work Evaluation, Personal & Social Adjustment, Food, Transportation) ***PSR**-Psychosocial Rehabilitation

☐ Supported Employment (**Task Oriented Rehabilitation Services(TORS)* (Work Opportunities services including Work Exploration, Job Coaching, Job Placement, Follow Up. ***TORS:For *TORS*, individuals must meet eligibility requirements**)

Please check one: ☐Meets **ADA criteria listed in ICM below** ☐Does not meet ADA criteria

☐ Peer Support(Recovery, Wellness, Daily Living Skills, Socialization and WHAM)

☐ **Intensive Case Management (ICM) & Community Transition Planning (CTP):** Individuals with SPMI who meet following ADA criteria:

Please check those that apply:

_____ Currently served in the State hospitals

____ Frequently admitted to the State hospitals, I.e.

--3+ hospitalizations in a 12 month period;

--10+ hospitalizations in lifetime;

--less than 30 day hospital readmissions;

____ Frequently seen in Emergency Rooms;

____ Chronically homeless;

____ Being released from jails or prisons; AND/OR

____ In forensic status and deemed appropriate for community services by relevant court

Referral Agency______________________________

Contact Person______________________________

Address____________________________________

Telephone__________________________________

Email ____________________________________

Fax ______________________________________

Name of Person completing the referral form:______________________________ **Date**_______________

****PLEASE NOTE THAT A CRIMINAL RECORDS CHECK MAY BE NECESSARY TO ACCESS CERTAIN CFI SERVICES****

Revised 7/19/18