

**REFERRAL FORM**

Client Name and # \_\_\_\_\_

Date: \_\_\_\_\_

**REFERRING AGENCY:** \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

**SERVICES REQUESTED:** \_\_\_\_\_

**CLIENT INFORMATION:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_ Email: \_\_\_\_\_

Gender: \_\_\_M\_\_\_F D.O.B: \_\_\_\_\_ Age: \_\_\_SSN: \_\_\_\_\_

Source of Income: \_\_\_\_\_ Monthly Amount: \_\_\_\_\_

Food Stamps: Yes \_\_\_\_\_ NO \_\_\_\_\_ Monthly Amount: \_\_\_\_\_

Military Service: Yes \_\_\_\_\_ NO \_\_\_\_\_ Type of discharge: \_\_\_\_\_

Parent/Guardian (if applicable): \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

**HISTORY OF HOMELESSNESS:**

Current Living Conditions: \_\_\_\_\_ How Long: \_\_\_\_\_

Length of Homelessness: \_\_\_\_\_ How many times homeless in the past three years: \_\_\_\_\_

**MENTAL HEALTH HISTORY:**

Mental Health Diagnosis \_\_\_\_\_

Present Treatment for Mental Health (agency and location) Medications/Dosage: \_\_\_\_\_

Recent hospitalizations (within the past year) Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, date and reason: \_\_\_\_\_

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Doctor/Therapist Name/PhoneNumber: \_\_\_\_\_

**DISABILITY HEALTH HISTORY:**

Disability Health Diagnosis: \_\_\_\_\_

Disability Certification Statement attached \_\_\_ Yes \_\_\_ No

Present Treatment for Disability (agency and location) Medications/Dosage: \_\_\_\_\_

Recent hospitalizations (within the past year) Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, date and reason: \_\_\_\_\_

Doctor/Therapist Name/PhoneNumber: \_\_\_\_\_

**MEDICAL:**

Medicaid: Applied for: \_\_\_ Yes \_\_\_ No \_\_\_ Accepted \_\_\_ Denied \_\_\_

Receiving \_\_\_ Number \_\_\_\_\_

Applied for SSI: \_\_\_ Yes \_\_\_ No \_\_\_ Accepted \_\_\_ Denied \_\_\_ Receiving \_\_\_\_\_

Applied for SSDI: \_\_\_ Yes \_\_\_ No \_\_\_ Accepted \_\_\_ Denied \_\_\_ Receiving \_\_\_\_\_

Insurance (Name of Provider) \_\_\_\_\_ Policy# \_\_\_\_\_

Name and Location of Primary Care Physician: \_\_\_\_\_

Medical Condition (including allergies): \_\_\_\_\_

Medications taken for any medical condition: \_\_\_\_\_

Any recent hospitalizations (within the past year) Yes \_\_\_ No \_\_\_ if yes, date and reason: \_\_\_\_\_

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**Smoke Cigarettes:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Substance Abuse History:**

How often does client use alcohol? \_\_\_\_\_ How often does client use other  
non-prescribed controlled substances? \_\_\_\_\_

Has there been use of controlled substance within the past year? Yes \_\_\_ No \_\_\_ Unknown \_\_\_\_\_

Drug(s) of choice: \_\_\_\_\_ Present Treatment for  
Substance Abuse (agency and location), \_\_\_\_\_

Counselor: \_\_\_\_\_ Past Treatment (inpatient or outpatient) for  
substance abuse: \_\_\_\_\_

**FORENSIC HISTORY:**

Does client have any charges or convictions related to Sex Abuse? Yes \_\_\_ No \_\_\_

Does client have any Felony Convictions? Yes \_\_\_ No \_\_\_

Is client currently on Probation or Parole? Yes \_\_\_ No \_\_\_

Has client ever been incarcerated for more than two (2) years? Yes \_\_\_ No \_\_\_

Does client have any pending Legal Charges? Yes \_\_\_ No \_\_\_

**LIVING SKILLS:**

Housing History and Patterns (Including timelines for homelessness if possible): \_\_\_\_\_

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Activities of Life (Hygiene, Housekeeping, Budgeting, etc.): \_\_\_\_\_

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Social Skills and Needs (Family Support, Social Functioning, Privacy Needs, etc.): \_\_\_\_\_

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E.S.P. Case Management Professionals, Inc.  
2090 South Nova Road AA-13  
South Daytona, FL 32119  
386-760-7533 Fax 386-761-5868

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Other Comments or Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Certification Statement**

I certify that this statement is true to the best of my knowledge and belief. I have attached all necessary documentation to support that the information provided is accurate.

\_\_\_\_\_

\_\_\_\_\_

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

Title

Phone Number

Agency: \_\_\_\_\_

**To be completed by RECEIVING STAFF:**

Date Referral was Received: \_\_\_\_\_

Date of Follow-up Phone Call or Interview: \_\_\_\_\_

Determination: Referral Accepted \_\_\_\_\_ Rejected \_\_\_\_\_ Date: \_\_\_\_\_

If Referral is Rejected, state Reason: \_\_\_\_\_

\_\_\_\_\_

Staff Signature: \_\_\_\_\_