REFERRAL FORM

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Referral Form	Today's Date:
Patient's Name:	**AMHI Consent Decree?** ☐ **Yes** ☐ **No** — **DOB:**
Gender: ☐ **M** ☐ **F** ☐ **Other:**	**Race:** — **Telephone:**
Health Insurance Company:	**Health Insurance ID:**
Address: — **City:**	**State:** — **Zip Code:**
Language: — **Interpreter Need?** ☐ **Yes** ☐ **No**	**Provider Requested:**
Substance Abuse? ☐ **Yes** ☐ **No** — **Is client in crisis?** ☐ **Yes** ☐ **No**	**Safety Concerns?** ☐ **Yes** ☐ **No**
Marital Status:	**Hispanic/Latino** ☐ **Yes** ☐ **No**
Service Requested	
☐ **Case Management**	☐ **Counseling/Outpatient Therapy**
Any Physical Disability? Yes ☐ **No** ☐ **If yes what's the disability:**	
Any Dental Needs? Yes ☐ **No** ☐ **If yes, explain:**	
Any Hospitalization? ☐ **Yes** ☐ **No**	**Date:**
List of Symptoms:	
Mental Health Diagnoses:	
Source of Diagnoses:	
At risk of being jailed? Yes ☐ **No** ☐ **At risk of hospitalization? Yes** ☐ **No** ☐	**At risk of homelessness? Yes** ☐ **No**☐
Emergency Contact Name: — **Relationship:**	**Phone:**
Referred by:	**Date:**
Organization Name: — **Email:**	**Phone:**
Signature: — **Name:**	**Date:**
To be Completed by Hand of Mercy Health Care	
Assigned Case Manager:	**Date:**
Assigned Counselor:	**Date:**

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