Referral Form for Methodist Residential Programs

Must be completed in FULL by Outpatient Therapist and fax back to (501) 421-6477

Client Name: _____ **Date Completed**: _____

SSN: _____ **DOB**: _____ **Age**: _____

Birth Gender: ☐ **Male** ☐ **Female** **Gender Identity (if applicable)**: ☐ **Male** ☐ **Female**

Medicaid	**Private Insurance**
PASSE Assignment:	**Insurance Carrier:**
PASSE ID #:	**Policy #/Group #:**

Provider Name: _____ **Therapist Name**: _____

Therapist Phone Number: _____ **Therapist email**: _____

Arkansas Total Care has their own form for referring clients. Please visit our **Make a Referral** page for that form or go to **bit.ly/3DWK8Lx**.

Family/Guardian Contact Information:

Name/Relation: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Psychiatric Diagnosis ICD-10 Code (F Code): _____

IQ/Functioning Level: _____

What psychiatric symptoms present that cannot be maintained at a lower level of care? Please be detailed & specific:

Other issues/behaviors impeding successful OP services and other social environmental success:

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How is this reflective of mental illness versus conduct related behavior?

Clients Current Location: ☐ Home ☐ QRTP/Foster Home ☐ Detention ☐ Hospital ☐Other _____

Current Members of Household

Please list current members of household, age and relationship to client:

Education:

School: _____ Grade: _____

If not currently attending school, please explain: _____

_____

Psychosocial Stressors:

☐ Birth	☐ Financial Difficulties in Family	☐ Parent Instability
☐ Custody Issues	☐ Health Issues in Family	☐ Peer Conflict
☐ Divorce/Separation	☐ Marriage	☐ Relocation
☐ Family Conflict	☐ Witnessed Violence	☐ Other

Legal Involvement: ☐ Yes ☐ No

Name & Number of Probation Officer:_____ County: _____

Reason for Legal Involvement:_____

_____

Primary Care Physician Name/Clinic and Contact Number: _____

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Current Risk Factors of Suicide:

☐ Child/Parent Conflict	☐ Isolation/Withdrawn	☐ Poor Impulse Control
☐ Crying Spells	☐ Lack of Appetite	☐ Restless
☐ Excessive Worry	☐ Mood Swings	☐ Sad/Depressed
☐ Fatigue	☐ Sleep Disturbance	☐ Hopeless
☐ Panic Attacks	☐ Feeling of Worthlessness	☐ Irritable/Agitation
☐ Peer Conflict	☐ Recent Loss	☐ Other

Current or History of Suicidal Ideations? _____

History of Suicide Attempts

Please list dates and method of attempt:

Self-Injurious Behaviors:

☐ None	☐ Bangs Head	☐ Punches Walls
☐ Bites Self	☐ Picks Sores	☐ Punches/Slaps Self
☐ Burns Self	☐ Pulls Hair	☐ Scratches Self
☐ Cuts Self	☐ Other	

Please explain the last occurrence of Self-Injurious behavior: _____

Risk Factors of Violence/Homicide:

☐ Blames Others	☐ Easily Annoyed/Annoys Others	☐ Oppositional
☐ Cruelty to Animals	☐ Gang-Related Activity	☐ Difficulty with Authority
☐ Lack of Remorse	☐ Serious Violations of Rules	☐ Other
☐ Use of weapons	☐ Violence towards others	☐ Destruction of Property
☐ Fire setting		

Current or History of Homicidal Ideations: _____

Provide details of risk factors of violence/homicide endorsed above:

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Psychosis/Functioning Factors
History of Psychosis:

Family History of Mental Illness, Medical Illness, or Substance Abuse:
Outpatient Treatment History:

Total # of Individual Sessions by LHMP within the last 90 days: _____
Have Individual Sessions been increased to address current issues? ☐ Yes ☐ No
Total # of Family Sessions by LHMP within the last 90 days: _____
Total # of Crisis Interventions within the last 90 days: _____
If so, state when and describe the outcome:

Date of most recent family/individual session attended: _____

If client has not had any outpatient sessions in the last 90 days and is in need of residential treatment, please explain their barriers to treatment and why residential is being recommended:

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Inpatient Treatment History:
Please list dates, locations and reasoning for admission:

Current Medications:
Please list medication name, dosage and frequency taken:

Does the client take medications as prescribed: ☐ Yes ☐ No

Has your client received any Home and Community Based Services (HCBS) in the last 90 days? ☐ Yes ☐ No
Please provide dates and details:

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Medical History **Height: _____ Weight: _____**

Current/prior medical diagnoses (i.e., diabetes, congestive heart disease, surgeries, etc.): _____

Does the patient require any assistive devices/services: ☐ Yes ☐ No

Allergies: ☐None ☐Drug ☐Seasonal ☐Other (If yes to any, please list all known allergies):_____

Substance Abuse History: ☐ Yes ☐ No

If yes, provide details to include frequency: _____

Is substance abuse a primary contributing factor to this referral? ☐ Yes ☐ No

Has patient completed or is patient attending drug treatment/groups? ☐ Yes ☐ No

If yes, provide details: _____

Trauma, Abuse, Neglect and/or Exploitation History (if yes, please note date, specifics of incident & those involved):

Sexual Abuse: ☐Yes ☐No _____

Physical Abuse: ☐Yes ☐No _____

Neglect: ☐Yes ☐No _____

Exploitation: ☐Yes ☐No _____

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Risk of Sexually Acting Out:

☐ None Reported	☐ Exposing Self to Others	☐ Multiple Partners within the Last Year
☐ Inappropriate Touching	☐ Sexually Active	☐ History of in Hospital SAO
☐ History of overly solicitous sexual behavior	☐ Allegations of Sexual Perpetration on others	☐ Excessive/Public Masturbation
☐Pending investigation/hx of founded SAC (P)	☐ Hx of making unfounded sexual allegations on others	☐ Other:

Same-Sex Attraction: ☐ Yes ☐ No

Symptoms of potential abuse (victim or perpetrator):

☐ None Reported	☐ Exposing Self to Others	☐ Multiple Partners within the Last Year
☐ Encopresis	☐ Enuresis	☐ History of in Hospital SAO
☐ Inappropriate Touching	☐ Allegations of Sexual Perpetration	☐ Excessive/Public Masturbation
☐ Low Functioning/Low Impulse Control due to ID/Neuro	☐ Sexually Active	☐ Encopresis
☐ Enuresis		☐ Other:

Therapist Signature/Credential **Date**

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