CRESCENT COUNSELING AND CASEWORK SERVICES

2328 Peters Creek Rd. NW Suite 102
Roanoke Virginia 24017
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Virginia Beach, VA 23452
Phone: (757) 431-0105 Fax: (757) 431-2608

REFERRAL FORM MENTAL HEALTH SKILL BUILDING

Name: _____ ☐ Male ☐ Female

Address: _____

Date of Birth:_____ Parent/Guardian: _____

Home Ph: _____ Work/Cell Ph: _____

Referred by: _____ Ph: _____

Medicaid #: _____ Social Security #: _____

Eligibility Requirements: Client must meet all three

1. **Client must have an SMI diagnosis**

Diagnosis:_____

Doctor who provided the diagnosis_____

2. **Client must have a prescribed psychotropic medication within the past 12 months**

Medication Prescribed:_____

Date Medication Prescribed:_____

Prescribing Doctor:_____

3. **Have a prior history of at least one of the following to be admitted into services: psychiatric hospitalization; residential crisis stabilization; Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or Temporary Detention Order (TDO) Pursuant to the Code of Virginia § 37.2-809 (B), evaluation as a result of decomposition related to serious mental illness.**

Type of facility services were provided:_____

Name of facility where services were provided:_____

Date of services provided:_____

Reason for Referral:

_____

_____

Actions take prior to this referral:

_____

_____