HOMER PERKINS CENTER
REFERRAL FORM

GENERAL INFORMATION

Referring Agency _____ Contact Person _____

Date_____ Phone _____ Fax # _____

PERSONAL INFORMATION

Client Name _____ Date of Birth _____Age _____

Gender M ( ) F ( ) SSN _____ Race _____

County of Residence _____ Zip code of county _____

DRUG OF CHOICE

Primary_____ Secondary _____ Tertiary _____

MEDICAL INFORMATION

Is there a history of mental illness? If so please describe_____

_____

_____

Is client on any medication? If so, please describe_____

_____

Has client had a complete physical/lab examination within the past year? Yes ____ No ____
Has client had a TB Test within the past 6 months? Yes ____ No ____

Name of Primary Care Doctor & Contact Info _____

Name of Mental Health Provider (if applicable) _____

LEGAL INFORMATION ***(If incarcerated, please check incarcerated and state which correctional facility he is housed at) (Please check all that apply)*** **Fax us the complete legal history as well.**

Parole ( ) Drug Court ( ) Probation ( ) Mandated ( ) Incarcerated ( ) DLR ( )

P.O. Name _____ Phone _____ Next Court Appearance _____

NYSID#_____ CJ Consent Date_____

DLR Referral Source if applicable_____

HOW HAS CLIENT BEEN TAKING CARE OF HIM/HERSELF FINANCIALLY? ,

_____

_____

IS CLIENT CURRENTLY RECEIVING ANY OF THE FOLLOWING: (*CHECK ALL THAT APPLY*)

( ) SSI and/or SSD
( ) DSS (Temporary Assistance/Public Assistance)

( ) Does Client have an open/active DSS/Public Assistance Case? OR
( ) Has client applied for DSS and is waiting for approval?

PRIOR TREATMENT *(start with most recent)*

Name of Facility	**Type of Treatment**	**Length of stay**	**S**	**US**
_____	_____	_____	___	___
_____	_____	_____	____	___
_____	_____	_____	____	___
_____	_____	_____	____	___

ADDITIONAL INFORMATION

_____

_____

_____

_____

DISCHARGE DATE

When is client due to be discharged from your program? _____

SCREENING SCHEDULED FOR:

DATE _____ DAY _____ TIME _____

APPOINTMENT WITH _____

PERSON TAKING THE REFERRAL _____