MHMR Tarrant

We Change Lives

Case #:_____
Name: _____
Medicaid #: _____

CRISIS SERVICES REFERRAL FORM

Referred to: ☐ RSP ☐ WCRU ☐ MCRU ☐ CARE House

CLIENT INFORMATION				
Client Name:	**Client ID:**	**Client Phone:**	**Client Location:** ☐Community ☐ Hospital	
Home Address:		**Current Address**		
DOB:	**SSN:**	**Gender:** ☐Male ☐Female	**Race/Ethnicity:**	**Language Spoken:**
Parent/Guardian Name:		**Parent/Guardian Phone:**		
Active Client? ☐ **Yes** ☐ **No**		**If Yes, which clinic?**	**# of Psychiatric Hospitalizations in the past: Year: 6 months:**	

PSYCHIATRIC HISTORY	MEDICAL HISTORY	SUBSTANCE USE HISTORY
Current DX:	**Current DX:**	**Current Substance Use:** ☐ **Yes** ☐ **No**
Current Psychiatric Medication(s):	**Current Medication(s):**	**Type of Substance(s) Used:**
Date medication last taken:	**Date medication last taken:**	**Last Date of Use:**

CONTACT INFORMATION OF REFERRING PERSON (*who completed this form*)			
Name:	**Phone:**	**Email:**	**Agency:**

REASON FOR REFERRAL (*please explain in detail the reason for the referral*)

CURRENT RISK AND SAFETY CONCERNS (*check all that apply & explain above*)

Yes	No		Yes	No	
☐	☐	Current Thoughts of Harming Another Person	☐	☐	Past Thoughts of Harming Another Person
☐	☐	Perpetrator of Violence/Abuse	☐	☐	History of Homicide/Manslaughter
☐	☐	History of Injuring another Person	☐	☐	Victim of Violence/Abuse
☐	☐	Current Thoughts of Self-Harm/Suicide	☐	☐	Past Thoughts of Self-Harm/Suicide
☐	☐	Prior Suicide Attempt (Most Recent Date:)	☐	☐	Recent Trauma Exposure
☐	☐	Current Substance Use/Abuse	☐	☐	Past Substance Use/Abuse
☐	☐	Criminal Justice System Involvement ☐Probation ☐Parole ☐Charges Pending ☐Time Served	☐	☐	Other: Multiple threats of physical harm

Please e-mail completed for to: Crisis.Services@mhmrtc.org
Please put name of unit referring to in the subject line.