

**Membership Requirements:**

1. Referral Form signed by Psychiatrist
2. Application/Assessment
3. Release Forms

Fax# 732-676-7891

**REFERRAL FORM**

**PROSPECTIVE MEMBER INFORMATION**

\_\_\_\_\_ (name) \_\_\_\_\_ (date of birth)

\_\_\_\_\_ (address) \_\_\_\_\_ (social security number)

\_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_ (phone number)

**DIAGNOSIS**

**MEDICATIONS**

Psychiatric \_\_\_\_\_ 1 \_\_\_\_\_  
 \_\_\_\_\_ 2 \_\_\_\_\_  
 \_\_\_\_\_ 3 \_\_\_\_\_  
 Medical: \_\_\_\_\_ 4 \_\_\_\_\_  
 \_\_\_\_\_ 5 \_\_\_\_\_

Medicaid Recipient?  yes  no \_\_\_\_\_ HMO   
 (name)

Reason for Referral/ Goals: \_\_\_\_\_

Behavior	History			
violence	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
suicide attempt(s)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
alcohol abuse	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
drug abuse	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
sexual exploitation	<input type="checkbox"/>	yes	<input type="checkbox"/>	no

Current Activity Level							
<input type="checkbox"/>	none	<input type="checkbox"/>	minimal	<input type="checkbox"/>	moderate	<input type="checkbox"/>	high
<input type="checkbox"/>	none	<input type="checkbox"/>	minimal	<input type="checkbox"/>	moderate	<input type="checkbox"/>	high
<input type="checkbox"/>	none	<input type="checkbox"/>	minimal	<input type="checkbox"/>	moderate	<input type="checkbox"/>	high
<input type="checkbox"/>	none	<input type="checkbox"/>	minimal	<input type="checkbox"/>	moderate	<input type="checkbox"/>	high
<input type="checkbox"/>	none	<input type="checkbox"/>	minimal	<input type="checkbox"/>	moderate	<input type="checkbox"/>	high

Describe any legal involvement: \_\_\_\_\_  
 Comments on any of the above: \_\_\_\_\_

**PSYCHIATRIST INFORMATION-PLEASE FILL OUT COMPLETELY**

\_\_\_\_\_ (name) \_\_\_\_\_ (phone)

\_\_\_\_\_ (address) \_\_\_\_\_ (date)

\_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

\_\_\_\_\_

**Psychiatrist Signature**

*(use additional paper, if necessary, for any aspect of this referral form)*