Straight Walk Family Services

REFERRAL FORM

Fax all referrals to 252-210-3415

Services Requested (check all that apply):

☐ Diagnostic Evaluation/Clinical Assessment
☐ Individual Therapy/ Family Therapy
☐ Group Therapy
☐ Psychiatric Evaluation / Medication Management
☐ Assertive Community Treatment Team
☐ Intensive Outpatient Program (IOP)
☐ Community Support Teams
☐ Peer Support Services
☐ DWI Treatment
☐ Other: _____

Referral Agency: _____ Referral Date: _____
Referral Phone: _____ Relationship to Client: _____
Client Legal Name: _____ Preferred Name: _____
Social Security # _____ DOB _____ Age_____

☐ Male ☐ Female ☐ Pregnant ☐ IV drug user

Client Phone: _____ Alternate Client Phone:_____
Physical Address:

_____

Legal Guardian: _____ Phone:_____
Address:_____

Is the Client a Minor? ☐ Yes ☐ No If Yes, Who Currently Holds Custody of the Minor Child?

_____

Home Address: _____
City: _____ State: _____ Zip Code: _____
Address Presented on Insurance Card: _____
City: _____ State: _____ Zip Code: _____

Emergency Contact:

- Name: _____
- Address: _____
- City: _____ State: _____ Zip Code: _____
- Email: _____
- Phone Number: _____

Does Straight Walk Have Permission to Contact the Emergency Contact if Client is Unable to Be Reached? ☐ Yes ☐ No

Marital Status: ☐Single☐Married☐Separated☐Divorced☐ Widowed ☐ Domestic Partners

Living Arrangement: ☐ Adult Care Home ☐ Homeless/shelter ☐ Private Residence ☐ Other Insured

Name: _____ DOB:_____
Relationship to Insured: _____ Insurance: _____

Benefits Verification Phone: _____

Insured ID # _____ Group # _____

☐ Copy of front and back of card attached

Insured Employer: _____

Medicaid# _____ Medicare# _____

County: _____ ☐ IPRS/Uninsured

Services

What mental health services is the client currently receiving? _____

Has the client previously tried a level of service lower than ACTT? ☐ Yes ☐ No

If yes, which service(s)? _____

Diagnoses

Has the client ever been diagnosed with a psychotic or mood disorder? ☐ Yes ☐ No

If yes, what disorder? _____

Note any severe psychiatric symptoms. _____

_____

Has the client ever been diagnosed with a personality disorder? ☐ Yes ☐ No

If yes, what disorder? _____

Has the client ever been diagnosed with mild or moderate mental retardation? ☐ Yes ☐ No

History of substance use? ☐ Yes ☐ No

Substance of choice: _____

Substance Abuse/Dependency/Treatment:

_____

Positive Drug Screens ☐ Yes ☐ No Positive for: _____

Medical

Current medications _____

_____

Medication history:

Is the client currently on any injectable medications? ☐ Yes ☐ No if yes, name of medication: _____

_____

Previously hospitalized for psychiatric reasons? Agency and dates, if known:: _____

_____

Primary Care Physician _____

What medical concerns does the client have? _____

_____

_____

☐ Danger to self or others History of: ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Legal issues ☐ History/Current of aggressive behaviors Details: _____

Social

Has the client ever had any legal charges? ☐ Yes ☐ No

If yes, list charges with dates. _____

_____

_____

What is the client's current living situation (homeless, surfing, group home, shelter, substandard housing)? What problems has the client experienced in maintaining housing? _____

Presenting Issues (check all that apply):

☐ Depression ☐ Anxiety ☐ Substance Use ☐ Trauma/PTSD

☐ Bipolar Disorder ☐ ADHD ☐ Anger Issues ☐ Suicidal Ideation

☐ Psychosis ☐ Self-Harm ☐ Family Conflict
☐ Other: _____

Current Risk Factors:
☐ Suicidal Thoughts ☐ Homicidal Thoughts ☐ Self-Injurious Behavior
☐ Aggressive Behavior ☐ Recent Psychiatric Hospitalization
If yes, please explain: _____

Additional ACT Criteria

Does the client have SSI or SSDI? ☐ Yes ☐ No
Does the client have difficulty performing daily living tasks? ☐ Yes ☐ No
Is the client currently unemployed or experiencing issues with work? ☐ Yes ☐ No
Explain: _____
_____
Does the client have problems getting medical services or making medical appointments? ☐ Yes ☐ No
Does the client have trouble avoiding common dangers to himself/herself? ☐ Yes ☐ No
If yes, please describe. _____
_____
_____
Does the client have any eating or nutritional concerns due to mental health symptoms? ☐ Yes ☐ No
If yes, please describe. _____
_____
_____
Is the client able to maintain his/her own finances and business affairs? ☐ Yes ☐ No
Does the client maintain his/her personal hygiene daily? ☐ Yes ☐ No
Other notes that may be relevant to ACTT: _____

Consent to Release Information (if applicable):
☐ Client has consented to this referral and information exchange
☐ Release of Information/Clinical Information attached

Submit referrals to: Referral@straightwalknc.com

Signature of clinician completing form: _____
Signature of psychiatrist: _____