NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH
Crisis Services Coordination Referral Form

REFERRAL SOURCE			
Person Making Referral:		Today's Date:	
Agency:		Telephone #:	
CLIENT INFORMATION			
Name *(Last, First, M.I.):*		Sex: ◯ Male ◯ Female	DOB:
Address:		Marital status:	Phone (H):
City:		◯ Single ◯ Partnered	Phone (M):
State:		◯ Married ◯ Separated	Phone (O):
Zip:		◯ Divorced ◯ Widowed	SSN:
Brief Description (to assist in locating or ☐ attach picture):			
Alternate Contact Info. (Significant others, family, etc.):			
Primary Insurance:		Secondary Insurance:	
Primary Insurance ID:		Secondary Insurance ID:	
REASON FOR REFERRAL/PRESENTING PROBLEM:			
Expected Jail Release Date:			
Charges/History of Violent Crimes:			
Pending Court Dates/Jurisdictions:			
Risk History:			
Arranged Post Release Appointments/Dates:			
Expected Services Needs Upon Release:			

Copy enclosed/ Faxed to 716-278-8130. Attention: Crisis Service Coordinator

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MEDICAL HISTORY	
Mental Health Diagnosis:	Initial Onset:
Substance Abuse:	Medical Problems:
PMD – Primary Medical Doctor:	

HISTORY OF PREVIOUS TREATMENT

Inpatient Treatment

Inpatient Setting:	*Dates:*	*Reason:*	*Outcome:*

Outpatient Treatment

Clinician:	*Dates:*	*Reason:*	*Outcome:*

MEDICATIONS(or ☐ copy MAR):

Medication:	*M.D. Monitoring*	*Side Effects:*	*Side Effect Severity*	*Note:*

CURRENT LINKAGES/SERVICES

	Telephone:	Ext.		
Agency:			Court System:	
Therapist:			Attorney:	Telephone:
Psychiatrist:			Parole:	
Care Manager:			Probation:	
SNAP: ◯ Yes ◯ No			Task:	
HEAP: ◯ Yes ◯ No			Mental Health Court:	
Medicaid: ◯ Yes ◯ No	Medicaid ID:		SPOA: ◯ Yes ◯ No	Date App. Comp.
Medicare: ◯ Yes ◯ No			AOT:	
SSI/SSDI: ◯ Yes ◯ No				

Other Comments/Notes & Additional Issues to be Addressed:

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