DBHIDS SOAR REFERRAL FORM

Safe Havens, Outreach, Journey of Hope, Housing First, TCM

To: **Patrick McNeil, SOAR Project Director**
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Note: fill out both sides completely and attach most recent psych eval and medication list from psych provider. All DBHIDS SOAR referrals must have a qualifying MH condition.

Referred By:

Date of Referral:_____

Name: _____ **Phone:** _____

Program: _____ **Email:** _____

Supervisor name and email: _____

Re: **Client:** _____ **Client Phone:** _____

Date of Birth:_____ **Date admitted to your program:** _____

Gender Identity: _____ **Race/ethnicity:**_____

Housing Status

Current Address: _____

Housing Program Name (if applicable): _____

Nature of Housing (shelter, voucher, program etc.)_____

At this address since (date):_____ Plan to move w/in 6 months? Yes_____ No_____

If yes, detail housing plan and estimated timeline: _____

_____

Mailing Address (if different): _____

Social Security History

Client been on disability before? Yes_____ No _____ Denied in the last year? Yes _____ No _____

If Denied, date of denial: _____ If Denied, did they appeal? Yes _____ No _____

Working with an attorney? Yes _____ No _____

If client is engaged with an attorney, we cannot enter into representation***

Nature of Disability *(all DBHIDS SOARs must have a qualifying mental health condition)*

Mental Health Diagnoses: _____

Current MH Medications and Dosages:_____

_____

Currently in MH Outpatient Treatment: Yes _____ No ____ If yes, since (date):_____

Outpatient Program Name: _____

MH Hospitalizations within Last 5 Years (hospital name and date):_____

_____

MH Symptoms that Prevent Client from Working: _____

_____

_____

Significant Medical Conditions, Providers, Treatments and Medications:_____

_____

_____

Drug and Alcohol Use History

Does client have a history of D/A use: Yes _____ No _____ Date last used: _____

Drug of choice: _____ Currently using: Yes _____ No _____

Note: If currently using opioids, clinician must complete a Medical Source Statement at time of referral.

Vocational Factors

Date range of most recent job: _____ Job title: _____

Date range of longest job held:_____ Job title: _____

Highest grade/degree completed: _____ Special ed in school? Yes _____ No _____

Note: attach most recent psychiatric evaluation and medication list.

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