



CRISIS REFERRAL FORM -

ADULT CRISIS RESIDENCE SUPPORT PROGRAM

126 Court Street Plattsburgh, NY 12901

Phone: 518 557 4500 Fax: 518-563-3704

Email: crisisreferrals@bhsn.org

Basic Client Information	Referral Date:
Legal Name:	Ethnicity:
(Physical) Address:	
County of Residence:	Preferred Name:
Phone #:	Preferred Pronouns:
Primary Language:	SSN#:
Primary Care Provider:	DOB:

Financial Information			
Insurance Policy:		Policy ID:	
Policy Holder Name:		Medicaid #:	
Policy Holder DOB:		Medicare #:	

Referral Information (Please ensure to give direct contact lines, for streamlined communication)	
Individual Making Referral Name:	
Representing which Agency/Hospital	
Address:	
Phone:	
Fax:	
Email:	

Mental Health History	
Current Mental Health Treatment? (Where)	
Mental Health Diagnosis?	
Treatment Compliance/Engagement?	
Current Medications?	



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Medical conditions/ Physical limitations: To include diabetes, Use of walker, etc.	
Inpatient Hospitalizations (Where, Dates of last 90 days, why?)	
Incarceration / Probation / Parole (Dates, Charges, Probation/Parole Contact information)	
Health Home Care Management? Community residence/supporte d housing?	

Known Risk Factors:	Present within 14 days	Past More than 14 days ago	No known History	Comments- must include most recent date, details, and impact
Suicidal (Ideation, attempts) <i>Include most recent Columbia</i>				
Violence				
Physical Harm to others				
Destruction of Property				
Domestic Violence / Restraining Orders				
Fire Setting				
Sexually abusive				



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Difficulty meeting basic needs				
Outbursts				
Command Hallucinations				
Drug/alcohol abuse				
Frequent Crisis Contacts				
Non-Suicidal Self Injurious Behavior				

Independent ADLs to include:	Yes	No	Limited with Support	Identify Support needs to accomplish ADL
Toileting				
Feeding				
Bathing				
Evacuating in Emergency				
Dressing				
Taking Medication				
Medical Needs				

Reason for CRISIS Residential Need
Current Acute Psychological/emotional change:
Client's current resources/supports:
Current symptoms of distress:



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How are current impairments in Mood/thought/behavior impacting client's home, school or community?	
What treatment services have been attempted to aid in managing the above distress so far and what was the client and family's response?	
What self-identified MENTAL HEALTH GOALS does the client feel prepared and willing to focus on during their admission to the crisis residence?	
Is Client aware of referral?	
Is Client in agreement with referral?	
Had Client been made aware that a referral does not guarantee placement?	
Discharge Location:	

**** ALL Referrals will be reviewed by the Program Clinical Team to include Program Director and Program Coordinator ****

Signature of Referral Source: _____ Date: _____

Reviewed By: _____ Date: _____

Referrals should be sent to crisisreferrals@bhsn.org and they will be reviewed by the Program Clinical Team to include Program Director and/or Program Coordinator within 24 hours. If the need is urgent, please send a referral via email and then contact Mobile Crisis via 1-866-577-3836. The Mobile team will review with Program Director and/or Program Coordinator upon receipt. *Additional documents can be faxed as needed to 518-563-3704.*