REFERRAL FORM

DBHIDS/SCA Recovery House Initiative | Email: RecoveryHouseReferral@Phila.gov|

City of Philadelphia
DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

Instructions: Please fill out and submit one form per person to the Recovery House Initiative

Does this individual give consent to provide the information below? ☐ Yes ☐ No

if no, please stop filling out this form

Participant's Information

Participant's First Name: _____

Participant's Last Name: _____

Participant's Social Security Number: _____

Gender (*please select one*):
☐Male ☐Female ☐ Transgender MTF ☐ Transgender FTM
☐Intersex ☐ Non-Binary ☐Other: _____

Is substance use disorder the primary diagnosis? ☐Yes ☐ No **If yes, please list the substance(s):**

_____

Date of Last UDS _____

Result of Last UDS ☐ Positive (Explain) _____ ☐ Negative

Participant's Race: ☐ African-American ☐Caucasian/White ☐ Asian/Pacific ☐ Other:_____

Participant's Ethnicity: (please select one)
☐ Hispanic ☐ Non-Hispanic

Date of Birth: _____

Type of funding? (please select one)
☐CBH ☐ BHSI ☐ VA ☐ Other: _____

Is the participant currently in treatment ☐ Yes ☐ No

If yes, which type: ☐ Inpatient ☐ Outpatient

Treatment Start Date _____

Have they attended all appointments? ☐ Yes ☐ No

Anticipated successful discharge date? *(Inpatient Only)*:

_____

What was or is their current living situation prior to treatment? (please select one):
☐ Street (Homeless) ☐ Living with Family/Friends ☐ Shelter ☐ Safe Haven ☐ Living Alone/Independent
☐ Correctional Institution ☐ Other: _____

Does this referral participate in MAT? ☐ Yes ☐ No
If yes, please specify:
☐ Methadone ☐ Suboxone ☐ Vivitrol/Naltrexone

Any ongoing medical issues? ☐ Yes ☐ No
if yes, please specify:

Issue(s):	Medication(s):
1.	
2.	
3.	
4.	

Is there a mental health diagnosis? ☐ Yes ☐ No
If yes, please specify: _____
Medication:_____

Any involvement with the criminal justice system?
☐ Yes ☐ No
If yes, Status/Charge: _____
☐ State ☐ Federal ☐ County (please select one)

PP ID: _____

Is this person Spanish speaking only? ☐ Yes ☐ No

Does this person need family housing? ☐ Yes ☐ No

If yes, Gender: _ _ **Child Age:** _____
Gender: _ _ **Child Age:** _____

Are there any areas in the city to avoid when referring?

_____

Outpatient Treatment Provider:

_____

Case Manager's Name:_____

Phone Number: (____) – _____– _____

Case Manager Type (please select one):
☐ FIR ☐ ICM ☐ PMHCC

Referral Source Information:

Referral Source Name: _____ **Date:** _____
(Last Name, First Name)

Email Address:_____

Agency: _____ **Phone Number:**_____

***For DBHIDS/SCA Staff Only*:**

Project Assistant Review:	_____ Signature	_____ Date
Project Supervisor Review:	_____ Signature	_____ Date
Referred to: Agency: _____		Program: _____