PROS REFERRAL FORM

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Date Completed: _____

INDIVIDUAL INFORMATION					
Name:		DOB:		❑ Male	❑ Female
Address: _____		Phone: _____(H) _____ (C) Email:			
Ethnicity:	❑ Caucasian	❑ African American	❑ Hispanic	❑ Asian	❑ Other (specify)
Primary Language:	❑ English	❑ Spanish	❑ ASL	❑ Other (specify)	
Marital Status:		Are you a Veteran?			
Highest Level of Education Completed:	❑ High School	❑ GED	❑ Some College	❑ Degree	
Religion:					
Current Legal Status:	❑ None	❑ Parole	❑ Probation	❑ Pending	
Living Arrangement:					
Emergency Contact:		Relationship:		Phone:	
Have you ever been a client of CNY Services in the past: ❑ Yes ❑ No. If yes, what program(s): _____					
Do you have a family member or significant other receiving mental health services at CNY Services? ❑ Yes ❑ No					

INSURANCE INFORMATION					
Social Security Number:					
Medicaid Number (sequence #):		County of Responsibility:			
Medicaid Option Plan: ❑ Yes ❑ No		If Yes: ❑ Blue Choice Option	❑ MVP	❑ Fidelis	
Other Insurance Provider:		Other Provider Number:			
Are you enrolled in any Medicaid Waiver Program? ❑ Yes ❑ No If Yes, provide contact information:					
Employment Status:		Occupation:			
Do you have a Medicaid spend-down: ❑ Yes ❑ No If Yes, spend-down amount: $					
Do you participate in Medicaid buy-in? ❑ Yes ❑ No					

Central New York Services PROS
375 W Onondaga Street, Suite 10
Syracuse, NY 13202
(315) 478-2030 | Fax: **(315) 478-2250**

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CURRENT SERVICE PROVIDERS			
	Name/Address	Phone	Fax
Primary Care Medical Provider			
Therapist			
Psychiatrist			
Case Manager			
Residential Contact			
Other Psychiatry Services			

PERSONAL GOAL INFORMATION

What are your life goals?

What barriers to those goals are you working to overcome?

What symptoms do you experience (check all that apply):

- ❑ Dangerous to self or others
- ❑ History of suicide, danger to self
- ❑ Self harm (self-injurious behaviors)
- ❑ Homicidal – danger to others
- ❑ Ritualistic behavior
- ❑ Depression/Mania
- ❑ Anxiety/Agitation
- ❑ Paranoia
- ❑ Hallucinations
- ❑ Severe mood swings
- ❑ Confusion/Disorientation
- ❑ Poor judgment/impulsivity
- ❑ Memory loss
- ❑ Socially withdrawn
- ❑ Sexual inappropriateness
- ❑ Non-compliant with medications
- ❑ Problems with eating
- ❑ Problems with sleeping
- ❑ Racing thoughts
- ❑ Other:

Describe your ability to participate, interact, and accept responsibility in group situations:

PSYCHIATRIC DIAGNOSIS

ICD 10 Code & Diagnosis _____

_____

_____

Previous psychiatric hospitalizations: _____ **Admission/Discharge dates:** _____

_____ _____

Previous Outpatient programs: _____ **Admission/Discharge dates:** _____

_____ _____

Current Medications: _____

Chronic Medical Conditions: _____

Special Needs: **Allergies** (Foods or Medications)**:**

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DRUG AND ALCOHOL SCREENING	
Please give a brief overview of your experience with drugs and alcohol: _____	
Age of first use: _____	**Substance(s) used:** _____
Date of last use:	**Substance(s) used:**
Have you ever received treatment for addiction and if so, please give provider and dates of service: _____	
Are you currently receiving substance abuse treatment or involved in self-help groups? If yes, please specify: _____	

REQUIRED SERVICES	
What mental health services might be helpful to you? Please check all that apply:	
❑	PROS Continued Recovery Support (CRS): classes, groups, and skills development opportunities to improve self care, life management, community living, social and work readiness skills.
❑	PROS Clinical Treatment: working with a prescriber, nurse, and therapist on medication and symptom management. (Must receive other PROS services as well).
❑	PROS Intensive Rehabilitation (IR): short term service to work intensely on a rehabilitation goal such as achieving a life role or intensive symptom management to avoid losing a life role.
❑	PROS Ongoing Rehabilitation Support (ORS): vocational support for individual currently employed at least 10 hours per week.

Please mail or fax the information requested below along with the Referral Form to:

Central New York Services PROS
375 W Onondaga Street, Suite 10
Syracuse, NY 13202
(315) 478-2030 | Fax: **(315) 478-2250**

Referring Individual (please print): _____ **Signature:** _____

Referring Agency: _____

Phone: _____ **Email:** _____

Please include:

- ❑ Clinical summary or current psychosocial history
- ❑ Current treatment plan (if applicable)
- ❑ Copies of insurance cards
- ❑ Current medication log (if applicable)
- ❑ Other psychiatric services client receives (for example, outpatient group)