Behavioral Health Outreach for Aging Populations Referral Form

Client Information					
Name			**DOB**		
Street Address			**Phone Number**		
Town/Zip			**Primary Language**		
Referral Source & Title:			**Referral Source Contact:**		
Race/Ethnicity	☐American Indian or Alaskan Native ☐Asian ☐Black or African American	☐Hispanic or Latino ☐Native Hawaiian or Other Pacific Islander ☐White	☐Multiracial ☐Prefer not to specify		
Gender	☐Female ☐Male ☐Transgender	☐Other (e.g., non-binary) ☐Prefer not to Specify	**Housing Stability**	☐Stable ☐Unstable ☐Unknown	
Behavioral Health Provider			**Number**		
PCP			**Number**		
Type of Housing	☐Privately Owned ☐Private Rental ☐Lives with Family/Friends (no cost)	☐Subsidized Housing (including congregate) ☐Assisted Living residence ☐Rest home	☐DMH/DDS/MRC group home ☐Nursing Facility		
Lives with?	☐Lives Alone ☐With family ☐With other non-relative individuals	☐Homeless ☐Other	**Impairments**	☐Deaf/Hearing-impaired ☐Blind/Visually impaired ☐Mobility-Impaired ☐Cognitively Impaired	
Emergency Contact Name & Number: **Is this person POA or Legal Guardian: ☐ Y ☐ N**					
Medical Diagnosis **(List only diagnosis pertinent to current situation)**					
Mental Health Diagnosis (List all)					

Please provide a list of current medications the consumer is taking.

Check any that have occurred in the last 30 days

☐More than 3 hospitalizations and/or ER visits for Mental Health related concerns/symptoms.
☐Utilization of Mobile Crisis or other Mental Health services (non-routine).
☐Frequent (2 or more a week) Cognitive and/or mental health symptoms that interfere with functioning or judgment
☐Unresolved protective services issues (current or recent involvement with PS including triage/screen out)
☐Medication Management/Compliance related concerns or issues
☐Resistant to care or interventions
☐Active substance abuse problem
☐Family/others create challenging dynamic
☐Socially isolated and/or hard to serve and/or would not reach out for help
☐Poor safety awareness

Executive Office of Aging & Independence

ASNCM
AGING SERVICES OF NORTH CENTRAL MASSACHUSETTS

Please answer the following questions to the best of your ability:

Is client aware this referral is being made (If not please explain)?
What if any specific symptoms can you provide? When did they start?
What is the impact of these symptoms on their day-to-day functioning?
Was there a trigger or recent event that caused the onset or worsening of symptoms?
Increased Risk? Is PS involved, or is there suspicion or reason for referral to PS?
☐Increased risk for decreasing ability to manage own Activities of Daily Living (ADLs) ☐Increased risk for unstable housing ☐Increased risk for financial instability ☐Increased risk for suicide or self-harm ☐Increased risk for abuse, neglect, or exploitation ☐Increased risk for significant health issues PS Involved: ☐ Yes ☐ No PS Referral: ☐ Yes ☐ No