Patient ID: _____ Site: Date: 10/16/2020

The purpose of this form is for your program to track clinic referrals. For example, you can use this information to identify sources of inappropriate referrals, and then take action to reduce inappropriate referrals. So, for the purpose of this form, a "Referral" is a request for program admission for a specific patient. In contrast, informal inquiries about the program would not be counted as a referral.

Patient ID (Patient Name or unique ID)	
Date Referral was Received:	
What was the urgency/level of need of the referral? 1) An **emergent need** is a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self. 2)An **urgent need** is a condition in which a person is not imminently at risk of harm to self or others, but by virtue of the person's substance use or condition, could rapidly deteriorate to an Emergent need without immediate intervention and/or diversion. 3)A **routine need** is a condition in which the person describes signs and symptoms resulting in (a) impaired behavioral, mental or emotional functioning which has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life, or (b) an impairment which can likely be diagnosed as a substance abuse disorder.	○ Emergent ○ Urgent ○ Routine
If this referral is for an **emergent** need, what happened when you received the referral? (Can check multiple)	○ Counselled referral source regarding obtaining emergency services ○ Scheduled a visit with your program within 2 hours of referral ○ Scheduled a visit with your program more than 2 hours after referral ○ Other:_____
If the referral was for a patient being discharged from an acute psychiatric inpatient facility, what is the date of discharge from the facility?	Date: _____
If the referral was for an **urgent** need, was there a bridging appointment with another provider between date of discharge from the provider and date of first appointment in your program?	○ Yes ○ No
If the referral was for a **routine** need, is the patient currently in treatment with another provider for the psychotic disorder?	○ Yes ○ No
Date referral screening was completed:	

Referral Source: (select all that apply)	○ Self-referred ○ Family ○ Inpatient psychiatric facility ○ Medical hospital ○ Mental health provider ○ Community health provider (e.g., PCP) ○ School system or university provider ○ Police or criminal justice ○ Day treatment program ○ Other (specify:_____)
County of Residence:	
Was assessment/consult appointment scheduled?	○ Yes ○ No
If an appointment was not scheduled, what was the reason? (may select multiple)	○ Could not reach ○ When contacted client declined appointment ○ Clinic not accepting new patients ○ Doesn't meet program admission criteria ○ Other (please specify:_____)
If appointment scheduled please complete following information:	
Clinic Email Address:	
Gender (Choose One):	○ Male ○ Female
Date of Birth (mm/dd/yyyy):	
Is patient being referred for program admission or for consultation only?	○ Admission Evaluation ○ Consult Only
Is this a new admission or transfer from another CSC program? (If readmission, please use Readmission Form rather than Referral Form.)	○ New Admission ○ Transfer

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