South Florida Behavioral Health Network, Inc.

Care Coordination Referral Form

Date of Referral: **Care Coordination Date of Admittance/Enrollment:**

I. Referral Information

Referring Agency:	**Name of Person of Contact (POC):**
POC Direct Office Line:	**POC Work Cell Phone Number:**
POC Email Address:	

II. Care Coordination Admission Requirements

Please choose at least one option from each row:

□ Serious Mental Illness (SMI)	□ Substance Use Disorder (SUD)	□ Co-occuring disorders
□ Awaiting admission into State Mental Health Treatment Facility (SMHTF)	□ Awaiting discharge from State Mental Health Treatment Facility (SMHTF)	
□ Three (3) or more acute care admissions within 180 days ○ CSU ○ Detox	□ Acute care admissions that last 16 days or longer ○ CSU ○ Detox	

Diagnosis(s):

III. Client Information

Legal Name:	**Date of Birth:**
Preferred Name:	**Social Security Number:**
Gender: □ Male □ Female □ Transgender □ M / □ F □ Other_____	**Phone Number:**

Race: **Ethnicity:**

Current Living Arrangements (prior to admission): □ Homeless □ If homeless, date Homeless Outreach was contacted:

□ Independent Housing □ ALF □ Family/Friends □ Residential Program:

Address:

Preferred Language: □ English □ Spanish □ Haitian-Creole □ Other (Specify):

Income Source: □ VA □ SSI □ SSDI □ Unemployed □Employed □None □ Other (Specify):

Insurance: □ None □ Applied/Pending □ Medicaid #: □ Medicare #

□ Private (Specify): □ Other (Specify):

Legal Status: □ Competent □ Incompetent	**Legal Guardian Name/Phone #:**

Forensic Status: □ None □ ITP □ NGI □ Court Hold/Charges □ Unknown

IV. Reason for Referral

Attach copy of most recent evaluation.
Preliminary treatment recommendations for continued care:

V. Follow-Up Appointment Details

□ Date of contact with treatment provider (If applicable):

□ Declined Care Coordination Services (Please complete discharge form)

Receiving Agency:	**Name of Care Coordinator (CC):**
CC Direct Office Line:	**CC Email Address:**
Name of Peer Specialist (if any):	**Peer Specialist Phone Number:**
Discharge Date:	**Date and Time of Follow-up Appointment (Within the next 7 days):**

□ Copy of Consent Form Attached

Transportation: **□ Yes, accessible transportation** **□ No accessible transportation**

□ If no accessbile transportation, please specify any recommendations/actions taken:

Referring Staff Signature: _____ Date: _____