

ALAMEDA COUNTY CRISIS RESIDENTIAL TREATMENT REFERRAL FORM

- Amber House, 516 31st Street, Oakland, CA 94609, Email referrals: amberreferrals@bayareacs.org. PH: (510) 379-4179
- Jay Mahler Recovery Center (JMRC), 15430 Foothill Boulevard, San Leandro, CA 94578. Telephone: (510) 357-3562
- Woodroe Place, 22505 Woodroe Avenue, Hayward, CA 94541. Telephone: (510) 428-1559

Referral Date:	Referring Agency:
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Referring Clinician Name:	Contact Number:
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CLIENT INFORMATION

Client Name:	DOB:	Age:
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Gender:	SSN or PSP:
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Primary Language:	Client Phone # (if applicable):
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Income Source/Amount:	Insurance:
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Conservator:	Alameda County Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Legal Status (PC290, 1370.01, etc):

Current Living Situation:	Is client able to return? (If no, state reason)
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Outpatient Services Team:	Outpatient Clinician:
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Contact Number and Email:

CLINICAL INFORMATION

Diagnoses (please include primary and secondary):

Substance Use (please include substances used and any withdrawal concerns, signs or symptoms):
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Risk Factors: <input type="checkbox"/> Danger to Self <input type="checkbox"/> Danger to Others <input type="checkbox"/> AWOL/AMA Risk <input type="checkbox"/> Other: Please elaborate on any checked boxes:
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Reason for referral (please include description of precipitating events as well as current symptoms):

Please list all current medications (include over the counter medications):

TB SCREENING/CLEARANCE

Has client ever had TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	PPD test in last 12 mos?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has client ever had BCG?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest X-Ray in last 12 mos?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Past exposure to TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when and where:		

SIGNS & SYMPTOMS: Check the appropriate box for any symptom that the client is currently experiencing:

Fatigue; Malaise	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unexplained weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia (loss of appetite)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fever (usually at night)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night sweats (drenching)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemoptysis (spitting blood)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain in chest	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PPD Administered Date:	PPD Read Date:
	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

Other infectious/contagious illnesses (Include signs of lice, bed bugs, scabies, etc.): Yes No If yes, describe:

PHYSICAL HEALTH STATUS

Medical Diagnoses (Please include treatment protocol and necessary follow-up):

Ambulatory Status: Ambulatory Ambulatory with assistive device* Non-ambulatory Bedridden

*If with assistive device, please indicate:	Does client have w/them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
	Can client transfer on own?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Physical Impairments

Capacity for Self-Care

Auditory impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Currently taking meds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visual impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can administer own meds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel/Bladder impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If on insulin, able to measure blood sugar and self administer insulin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe:				<input type="checkbox"/> N/A	
Able to care for any wounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bathes/Dresses/Feeds Self	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other impairments:			Able to leave unassisted	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mental Status

Special Diet:

Confused	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergies:
Able to follow instructions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Able to communicate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Print MD Name:	Facility Name:
MD Signature:	Date: