Consumer Name: _____ Medicaid Number: _____

HELTON HOUSE INC.
REFFERAL SCREENING FORM
PHONE: (434)392-9276 FAX: (434)392-1509

This referral is for the following Helton House, Inc. service(s):

☐ Group Day Services/Community Engagement ☐ Residential Services

***** Please attach the consumer's most recent psychiatric, psychological, and neurological exams *****

I. IDENTIFYING INFORMATION

Full Name: _____ Gender: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

Telephone Number (if applicable): _____

Marital Status: _____

Emergency Contact

Name: _____

Address: _____

Telephone Number: _____

Relationship to consumer: _____

Legal Guardian

Name: _____

Address: _____

Telephone Number: _____

Consumer Name: _____ Medicaid Number: _____

Case Management

Support Coordinator Name: _____

Agency/Community Service Board: _____

Phone Number: _____

Primary Care Physician or Regularly Used Medical Practice

Physician Name: _____

Agency: _____

Phone Number: _____

Psychiatrist/Nurse Practitioner

Name: _____

Agency: _____

Phone Number: _____

Other Medical Professional or Counselor

Name: _____

Agency: _____

Phone Number: _____

Consumer Name: _____ Medicaid Number: _____

II. REFERRAL SOURCE INFORMATION

Name: _____

Address: _____

Telephone Number: _____

Relationship to consumer: _____

Please describe any family/friend relationships including family/friend phone number.

_____
_____
_____
_____

Reason for Referral: *(please include whether purpose is for further assessment, placement on a waiting list, or admission to the service)*

_____
_____
_____
_____

Directions to the consumer's residence:

_____
_____
_____
_____

III. PSYCHIATRIC HOSPITALIZATIONS

Number of psychiatric hospitalizations: _____

Most recent admission and discharge date in last 12 months:
_____

Was this hospitalization Voluntary of Involuntary: _____

What were the precipitating factors?
_____
_____
_____

Consumer Name: _____ Medicaid Number: _____

IV. Criminal Justice Status

Number of incarcerations: _____

Reason(s) for incarceration:

_____
_____
_____

Current Criminal Justice Status (if applicable): _____

V. Consumer Health

Allergies: _____

Consumer's mental/intellectual diagnosis:

_____
_____

Consumer's health disorder(s):

_____
_____
_____

What is the onset/duration of the consumer's medical, mental and/or behavioral problems?

_____
_____
_____

Does the consumer have an infectious disease? ( ) No ( ) Yes -

_____

Does the consumer have a history of seizures, convulsions with high temperatures, fainting spells or staring spells? ( ) No ( ) Yes -

_____

Does the consumer require a specialized diet? ( ) No ( ) Yes -

_____

Consumer Name: _____ Medicaid Number: _____

What is the consumer's substance use and abuse history? (including nicotine):

_____
_____
_____

History of medical hospitalizations:

_____
_____
_____
_____

Serious illnesses and/or chronic conditions of parents and siblings:

_____
_____
_____

Please check all that apply:

Orthopedic Devices:

☐ Wheelchair ☐ Braces ☐ Helmet ☐ Walker ☐ Toilet Chair
☐ Shower Chair ☐ Other - _____

Speech:

☐ Speech Understandable ☐ Sign Language ☐ Non-Verbal
☐ Computer Communication Board ☐ Other - _____

Physical Handicaps:

☐ Wears Glasses ☐ Legally Blind ☐ Tunnel Vision ☐ Hearing Aid
☐ Hearing Loss ☐ Other - _____

Consumer Name: _____ Medicaid Number: _____

Current Medications:

Date Prescribed	*Medication*	*Dose*	*Route*	*Schedule*	*Physician*

VI. CONSUMER NEEDS (select all that apply and describe above):

- ☐ **Medication Management**
- ☐ **Contact/follow up with medical provider**
- ☐ **Health monitoring**
- ☐ **Recreation/leisure supports**
- ☐ **Personal hygiene**
- ☐ **Activities of daily living**
- ☐ **Communication skills**
- ☐ **Money management**
- ☐ **Interpersonal skills**
- ☐ **Conflict resolution**
- ☐ **Other:** _____

VII. Behavior Issues

Please described the consumer's behavioral history (harm to self and/or others):

_____
_____
_____
_____
_____

Consumer Name: _____ Medicaid Number: _____

VIII. Educational and Vocational History

What was the last grade the consumer completed? _____

If the consumer graduated, what type of diploma was received?

_____

Did the consumer have any issues (mental, behavioral, and medical) in school?

_____

_____

Please describe the consumer's vocational history:

_____

_____

_____

Please complete the following if the consumer is being referred for residential services.

- SSI Monthly Amount: _____
- SSA Monthly Amount: _____
- SSDI Monthly Amount: _____
- Other - _____
- Medicare Number (if applicable): _____

Printed Name of Referral Source: _____

Signature of Referral Source: _____ Date: _____

Consumer Name: _____ Medicaid Number: _____

For Helton House Use Only:

Status of consumer:
(☐) Accepted (☐) Waiting List (☐) Not Accepted -
_____
_____

Rational for Acceptance
_____
_____
_____
_____

_____
Program Director **Signature** **Date**