

**GEORGIA REHABILITATION OUTREACH, INC.
REFERRAL SCREENING FORM**

Date of Referral: _____

Consumer Informed of Referral? Yes No

Demographic Information

Consumer Name: _____ Address: _____

Date of Birth: _____

Telephone #: _____ S.S.#: _____

Gender: M _____ F _____ Race: _____

Consumer Lives With: _____

Financial Resource: Medicaid Medicare Private Insurance None

Social Security Amount _____ SSDI Amount _____

Retirement Amount _____ Payee Name: _____

Veteran's Administration Benefits

Emergency Information

Emergency Contact: _____ Relationship: _____

Telephone #: _____

Referral Source Information

Referred By: _____ Organization/Agency: _____

Other Agencies/Family Involved: _____

Address: _____

Telephone #: (Mandatory) _____ Fax #: _____

Email Address _____

Reason for Referral: _____

Immediate/Urgent Needs _____

Strengths/Skills/Abilities: _____

Mental Health Information

Please check all that apply

Hospital Admissions [] 3 times in last 12 mos. [] 2 times last 6 mos [] 60 consecutive days

Name of Hospitals and Hospitalization Admit and Discharge Dates:

Reason for Hospitalization: _____

Emergency Room Visits and Dates: _____

Psychiatric Diagnosis:

Axis I: _____

Primary

Axis I: _____

Secondary

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Current Medication(s): *(Please include dosage)*

1. _____ 3. _____

2. _____ 4. _____

PHYSICIAN (S): _____

Legal History Information:

Status: [] Forensic Conditional Release [] Outpatient Commitment [] Expiration Date: _____

List Criminal Offenses and Dates _____

Hearings/Trials Pending and Dates _____

Probation/Parole Officer Name: _____ Phone #: _____

Danger to Self/Others: Violence Towards Self Violence Towards Others Violence

Towards Property Sexual Assault Fire Setting Non-medication compliance

Describe:

Check All That Apply:

Difficulty with the Following:

Finances Executing Personal Care Skills Transportation Family Relationships

School/Vocational Interpersonal Skills Social, leisure activities Household Tasks

Describe Relationship with Family:

**A check mark below indicates that consumer, referring professional, and family are in agreement with referral:*

Consumer agrees with referral to GRO, Inc.

Consumer Family Member(s) agree with referral to GRO, Inc.

Psychiatrist agrees with referral to GRO, Inc.

Referring professional agrees with referral to GRO, Inc.

AGENCY USE ONLY

Disposition:

Assigned To: _____ Date: _____

Status:

Accepted Enrollment Date _____

Pending Reason _____

Denied Reason _____