GLSS **Greater Lynn Senior Services**

REFERRAL FORM: Mobile Mental Health(MMH) • Family Abuse Program(FAP) Behavioral Health Outreach for Aging Populations(BHOAP)

Referral Date: _____ **Program Requested:** ☐ **Mobile Mental Health** ☐ **Family Abuse Program** ☐ **Behavioral Health Outreach for Aging Populations**

REFERRAL SOURCE

Name of referral source: _____ **Agency/Relationship:** _____

Address: _____ **City/State:** _____

Phone: _____ **Email:** _____

Is the client aware of referral? ☐ **Yes** ☐ **No** **Is the client willing to receive a call from the clinician?** ☐ **Yes** ☐ **No**

If "No," please explain: _____

CLIENT INFORMATION

Name: _____ **DOB/Age:** _____

Address: _____ **City/State:** _____

Phone: _____ **Email:** _____

Race/Ethnicity: _____ **Language:** _____ **Gender:** _____

Marital Status: _____ **Others living in the home:** _____

Emergency Contact Name: _____ **Relationship:** _____ **Phone:** _____

Primary Insurance and Member ID/number: _____

Secondary Insurance and Member ID/number: _____

Is the client appropriate for telehealth (virtual or telephone): ☐ **Yes** ☐ **No**

Can the client access the telephone independently: ☐ **Yes** ☐ **No**

Does the client have access to a computer/internet: ☐ **Yes** ☐ **No**

If "No," please explain: _____

Presenting Issue (describe the reason for referral):

Level of risk: ☐ **Low** ☐ **Medium** ☐ **High** **Please explain:** _____

Primary Care Physician: _____ **Phone:** _____

Health/Medical Diagnoses: _____

Medications: _____

Memory loss: ☐ Yes ☐ No **If "Yes," please explain:** _____

Mental Health Providers/Agency: _____

Psychiatrist/Prescriber/Agency: _____

Mental Health Diagnoses: _____

Past/Previous Mental Health Treatment: _____

Loss/stressors: _____

Trauma history: _____

Addictions/Substance Abuse: ☐ Yes ☐ No **If "Yes," please explain (include history of addictions/substance use/abuse):**

_____

Condition of the home: _____

Are there pets in the home: ☐ Yes ☐ No **If "Yes," please explain:** _____

Hoarding behavior: ☐ Yes ☐ No **If "Yes," please explain:** _____

Infestation: ☐ Yes ☐ No **If "Yes," please explain:** _____

Weapons: ☐ Yes ☐ No **If "Yes," please explain (include if weapons are locked/secure):**

_____

Risk to worker: ☐ Yes ☐ No **If "Yes," please explain:** _____

Does the client have a Protective Service Worker: ☐ Yes ☐ No

Does the client receive Homecare Services: ☐ Yes ☐ No

If "Yes," Case Manager's Name and Agency: _____

Is this client currently enrolled in the Homecare CHOICES or Homecare Basic Waiver Program: ☐ Yes ☐ No

Other services in the home: _____

Other formal/informal supports: _____

FOR FAMILY ABUSE REFERRALS:

Who is considered the alleged perpetrator: _____

What is the alleged perpetrator's relationship to the client: _____

Does the alleged perpetrator live with the client: ☐ Yes ☐ No

Please describe any safety concerns: _____

What is the best way to contact the client: _____

Referral form completed by: _____ **Department/phone #:** _____

Please send completed intakes, via secure email, to Ddavies@glss.net and Cmurphy@glss.net