Chums Referral Form

FORM MUST BE PRINTED OR TYPEWRITTEN Date: _____

Referring Agency: _____

Referring Party Name:_____Phone:_____Ext._____

Name: _____ Birth Date: ____/_____/_____ Phone: _____

Street Address: _____City: _____State: _____ Zip: _____

Social Security Number:_____

Gender: ☐ Male ☐ Female ☐ Unknown

Race: ☐ Black/African American ☐ White ☐ Alaskan Native
☐ American Indian ☐ Asian ☐ Other Single Race
☐ Two or More Race ☐ Unknown

Ethnicity: ☐ Cuban ☐ Mexican ☐ Puerto Rican
☐ Unknown ☐ Other Specific Hispanic ☐ Not of Hispanic Origin

Military Status: ☐ None ☐ Discharge ☐ Active Duty
☐ Disabled Veteran ☐ Afghanistan Veteran ☐ Iraqi Veteran

What is the client's mental health diagnosis?

	Name	DSM Code	IV	V
Primary	_____	_____		
Secondary	_____	_____		
Tertiary	_____	_____		

Diagnosis Type: DSM-IV-TR ☐ DSM-V ☐ ICD9 ☐ ICD10 ☐

Special Population:

☐ Severely Mentally Disabled ☐ Alcohol/Other Drug Abuse ☐ Forensic Legal Status

☐ Deaf/Hearing Impaired ☐ Blind/Sight Impaired ☐ Physically Disabled

☐ Speech Impaired ☐ Physical Abuse Victim

☐ Mental Retardation/Developmentally Disabled

Frequency of attendance at self-help programs in the 30 days prior to admission:

☐ No attendance in the past month ☐ 1-3 times in the past month ☐ 4-7 times in the past month

☐ 8-15 time in the past month ☐ 16-30 times in the past month ☐ Unknown

☐ Some attendance in the past month, but frequency unknown

Psychosocial Rehabilitation

Client could benefit from:

- ☐ Taking more responsibility for how he/she lives their life.
- ☐ Obtain the information/skills needed to take charge of managing their illness
- ☐ Learn how to deal more effectively with daily problems.
- ☐ To be able to control his/her life.
- ☐ To be able to handle things when they go wrong.
- ☐ To be better in social situations
- ☐ Bothered less by symptoms related to his/her mental illness.
- ☐ To be able to do things that is more meaningful in his/her life.
- ☐ To be better at taking of his/her needs.
- ☐ Maintain/enhance his/her ability to live in current level of care setting.

Please attach a copy of the participant's current

Individualized Service Plan and most recent Diagnostic Assessment

Mail, Fax or Scan to:

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