



“HELPING HANDS THAT HEAL”

Mental Health Skills-Building Services

Referral Form

Phone: (434) 630-8494 Fax: (888) 767-7937

Date of Referral: \_\_\_\_\_

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

SSN: \_\_\_\_\_ Race: \_\_\_\_\_

Medicaid#: \_\_\_\_\_ HMO Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Presenting Problems/Risk Conditions:

List present/past services being received: (in home counseling, group home, day treatment, outpatient therapy, case management)

How did you hear about TPI? \_\_\_\_\_

If Referral given by someone other than client:

Referral Source Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

TPI employee completing referral: \_\_\_\_\_

Client must meet **ALL** of the following criteria:

- Individual has a history of psychiatric hospitalization, Intensive Community Treatment, crisis stabilizations services, PACT (Program of Assertive Community Treatment), Residential Treatment or TDO.
  
- Individual needs assistance with activities of daily living related to symptom management, compliance with psychiatric and medication treatment plans, development of social skills and support systems, person hygiene, food preparation, or money management.
  
- Individual has been diagnosed with one of the following diagnoses: Bipolar I or II, Major Depressive Disorder, Schizophrenia, or other psychotic disorder or another Axis I disorder that is severe and debilitating and documented by a physician.
  
- Individual has been on a psychotropic medication in the past 12 months.  
Name of medication: \_\_\_\_\_  
Prescribing Physician: \_\_\_\_\_