

**SPRING STREET SHELTER &
SPRING STREET TRANSITIONAL HOUSING
REFERRAL FORM**

Return this form by faxing to (650) 368-2534
or by mail to MHA, 2686 Spring St., Redwood City, CA 94063
(2/05)

Place a check next to the program to which you are referring your client:

SPRING STREET SHELTER _____ SPRING STREET TRANSITIONAL HOUSING _____

CLIENT NAME: _____ REFERRAL DATE __/__/__
Mental Health Number (MIS): _____
Referring Person: _____ Phone: _____
Agency/Program: _____

Demographics

Birth Date: __/__/__ Age: ____ Soc. Sec. Number: _____
Sex: ____ Race: ____ Primary Language: _____ Religious Preference: _____
Client's Current Address & #: _____
Next of Kin: (Name/Address/#/Relationship) _____

Last Year of School Completed: _____ Marital Status: _____
Legal Status: Vol. ____ Conserved ____ T-Con ____ Con Rep ____ Parole/Probation ____
Restraining Order? _____
Legal Issues or current legal problems: _____
Is client a veteran? Yes ____ No ____ Receive VA Services? Yes ____ No ____

Diagnosis:
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Medications and Dosage:	Prescribed by:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Rehab. Team
(Names and Phone Numbers)

Conservator/T-Con _____
Case Manager _____
Psychiatrist _____
Therapist & Region _____
Parole Prob. Off. _____
Voc. Counselor _____
Primary Care Doctor _____

Brief Psychiatric History

Number of psychiatric hospitalizations: _____ Circumstances of most recent hospitalizations:

Date of most recent seclusion and circumstances: _____

Signs of decompensation: (Please be as specific as possible about what we should look for)

Describe current functioning level:

Suicide Attempts: Yes: ___ No: ___ Date of most recent attempt: ___/___/___

If yes, please describe: _____

History of violence (homicidal/assaults/arson/property destruction): Yes ___ No ___

Date of most recent incident ___/___/___

If yes, please describe: _____

History of drug or alcohol abuse: No ___ Yes ___ If yes, types _____

If yes, has there been any treatment and where. _____

History of eating disorder : Yes ___ No ___

If yes, please describe. _____

If yes, has there been any treatment and where. _____

Presenting Psychiatric Symptoms

Response to medications: Symptoms alleviated _____ Symptoms persistent _____

If persistent, please describe: _____

Does the client know how / remember to take medication as prescribed? Yes ___ No ___

Social Support

Level of family involvement/social support (i.e. friends, church group):

Day Activities

Current Activities: _____

Referrals to community resources in progress (e.g. VRS, School, Supported Employment, ROP).

Vocational history and current work status: _____

Financial Information

1. Gross monthly income: \$ _____
2. Source of income: ___ General Assistance ___ SSI ___ SDI ___
V.A. ___ (% service connection?) ___ Job ___ Social Security ___ Family ___
Other _____
3. Is client under Rep. Payee ? No ___ Yes ___ If yes, who ? _____
4. Is SSI Pending ? Yes ___ No ___ If yes, approximate date of benefits: _____
5. MediCal # _____ Pending? _____
MediCare # _____ Pending? _____
6. Other Insurance ? _____

Client's Life Skills

Personal Hygiene	___ Wears dirty clothes, rarely bathes.	___ Usually needs prompting to change Clothing & bathe.	___ Sometimes needs prompting to change clothing.	--- Able to take care of personal hygiene without prompts.
Handling Money	___ Gives away money indiscriminately	___ Spends money as soon as it is received.	___ Occasionally tries to budget money.	___ Careful about spending money & Tries to save.
Literacy	___ Functionally literate	___ Reads & writes very little.	___ Can understand & complete forms.	___ Reads for pleasure.
Appointments	___ Always needs reminders to get to appointments.	___ Sometimes needs assistance & reminding to get to appointments.	___ At times, needs to be reminded.	___ Is able to get to appointments without being reminded.
Use of Public Transportation	___ Refuses or is unable to take the bus.	___ Uses only when accompanied.	___ Sometimes takes the bus alone.	___ Often uses the bus.
Involvement in Social Activities	___ Makes no attempt to socialize; resists involvement.	___ Will participate in light, low stress, social activities.	___ Usually participates in activities.	___ Actively participates in activities.
Cooking	___ Not able to cook for self.	___ Needs constant close supervision.	___ Needs some assistance.	___ Able to cook for self.
Housekeeping	___ Does not see dirt.	___ Needs close supervision.	___ Needs some Assistance/direction.	___ Cleans room, Does laundry, shares In chores.

For referrals to temporary housing facilities, what is the future housing plan for this person?

Signature of individual making referral _____