# **Intensive Family Support Services (IFSS) - Family Access to Support and Information (FASI)**


# **Middlesex County Referral Form**

# **Phone: 732-235-6184 Fax: 732-235-7221 E-mail:** **ubhc-community-services@ubhc.rutgers.edu**

**Referral Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_**

**Referral Source** *(Name /Agency):***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Phone #: ( \_\_\_ ) \_\_\_\_- \_\_\_\_\_\_**

*(Please ensure family is aware of referral to IFSS.)*

**Primary Family Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relationship to Consumer:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 *First Last*

**Family Address** *(street, city, zip)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone #: ( \_\_\_ ) \_\_\_\_- \_\_\_\_ Cell Phone #: ( \_\_\_ ) \_\_\_\_- \_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Language of Family**:  English  Spanish  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consumer Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_/ \_\_\_\_ / \_\_\_\_\_\_

 *Last First*

Does Consumer live at home? Yes No Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Referral:**

Family Member in Crisis

Substance Abuse

Alcohol Abuse

Illness in Family

Financial Issues

 Psychoeducation Needed

Death in Family

 Self Help Resources Needed

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give additional detail for reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Diagnosis:** Schizophrenia Bipolar Disorder Major Depression Anxiety Disorder Substance Abuse Alcohol Abuse Borderline Personality Disorder Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referral source does not know the Diagnosis

**Date of last Hospitalization:** From \_\_\_/\_\_\_/ \_\_\_ to \_\_\_/ \_\_\_/\_\_\_ **Name of Hospital:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Violence:**  No  Yes If yes, briefly explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment History:**  Outpatient Services  Partial Hospital  Inpatient Unit  State Hospital  Prison

 Co-occurring  Case Management  None  Other Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Treatment:**  Outpatient Services  Partial Hospital  Inpatient Unit  State Hospital  Prison

 Co-occurring  Case Management  None  Other Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Entitlements:**  SSI  SSDI  Medicaid  Medicare  Private Insurance General Assistance  None

**CURRENT MEDICATIONS**

|  |  |
| --- | --- |
| **Name Dosage Frequency** | **Name Dosage Frequency** |
|  |  |
|  |  |

***FOR IFSS STAFF ONLY*****Date Referral Received: \_\_\_\_ / \_\_\_\_ / \_\_\_****Follow up:**  Phone Primary Contact Phone Referral Source Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IFSS Staff Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UBHC ID#: \_\_\_\_\_\_\_\_\_

 *Print*

**Assigned IFSS Staff** *(signature, credentials)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_