



RUTGERS HEALTH

University Behavioral Health Care

Intensive Family Support Services (IFSS) and

Acute Care Family Support (ACFS)

Middlesex County Referral Form

Phone: 732-235-5000 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/ACFS)

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 ☐ Illness in Family ☐ Death in Family
☐ Substance Abuse ☐ Financial Issues ☐ Self Help Resources Needed
☐ Alcohol Abuse ☐ Psychoeducation Needed ☐ Other _____

Please give additional detail for reason for referral: _____

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) _____