Referral Type:
Self ____Other__ (if other pls provide info below)
Organization: _______________________________
Contact Person: __________
Relation to Patient: __________________________
Phone:________________

CHOICE COMMUNITY HEALTH

8700 Central Ave Suite 207 Landover MD, 20785 Ph: 240-222-2525 Fax: 240-767-4804

Please complete the form so we can better serve you. CCH serves both individuals with private insurance, Medicaid and the uninsured.
Please indicate service(s) for which you are referring this individual:

Mobile Treatment Services : ____________ **Psychiatric Rehabilitation Program** : _____

Patient Name____

Referral Date__________________

Address____

Apt______________ City____

State______ Zip Code: -----------------

Phone: ___________ DOB :______________ SSN_______________

Gender : Male________ Female: ____

Race : American Indian/Alaskan Native ___Asian ____Black/African American ____Native Hawaiian/Other Pacific Islander ____White Ethnicity ____Hispanic or Latino ____Not Hispanic or Latino
Marital Status ____Single ____Married ____Divorced Smoking ____yes ____no If yes, how many packs/day? _______ Is the Patient a Veteran? ____Yes ____No ____Unknown
If yes where?______

Emergency Contact____________________________
Relationship to patient: _________________________________ Phone: __________________________

Rep payee (if applicable) ____
Relationship to patient: _________________________________ Phone: ________________________

Probation/Parole Officer (if applicable): ____________________ Phone:__________________________

Are you Employed? ___Yes ___No If yes, where________-________________________________If no, are you actively looking for employment? ___yes ___no

Does the Patient have any type of medical insurance? _______________________

Insurance Carrier: _____________________________ ID #: ________________________

If potential Patient is uninsured, one of the following eligibility criteria must be checked:

Discharged from a Maryland psychiatric hospital or residential crisis bed within the past 3 months ? ____

Are you Homeless? ________ Do you receive SSDI for mental health reasons? _____________
Have you received services in the public mental health system within the 2 years? _______________

Are you released from Dept. of Corrections/prison/jail within the past 3 months ? ___________

Are you referred by order of a Conditional Release ? _____________

Where is the Patient living? ____

Briefly describe the Patient's need:
____
____
____

Any history of psychiatric hospitalizations: ___Yes ___No If yes, please indicate facilities and dates of hospitalization:
____
____
____

Please provide discharge paper if available.
Any history of court charges and incarcerations (check where applicable):
Drug-Related ___ Theft _______ Assault ___ Weapons Possession ___Sexual assault ____
Other type of arrest within the past 90 days __________

Current Medications(s)/ dosage, .please include prescriber name:
____
____
____

Has Patient ever been diagnosed with Asperger's, Pervasive Developmental Disorder (PPD), Autism or any other type of developmental disability? Yes ___No____ If yes, what was the diagnosis? _________
Is Patient under a doctor's care for the above mentioned condition? Yes ___No____ If yes,
Include physician name______________________________

List all Mental Health Diagnosis (if known):

____

____

List other Social/Environmental/Physical Health Issues:

____

____

Additional Contacts:

Physician: ___________________ Phone: _________________________

Case Manager: _____________________ Phone: _________________________

Psychiatrist: _________________________ Phone: _________________________

Therapist: ________________________________ Phone: __________________________

Patient Authorization/ Agreement:

I wish to receive services from Choice Community Health and I am authorizing the agency to provide services to me.

Patient Signature: ______________________________Date: ____________________

FOR CHOICE COMMUNITY HEALTH STAFF ONLY

Name of CCH Staff receiving this referral: ________________________________

Date Received :_________________________

Does this include discharge documents? Yes _____________ No _______