Region 1 Behavioral Health Authority
Emergency Community Support
Referral Form

Please Fax to Sue Teal @ (308) 632-2326 or email securely to steal@region1bhs.net
Needs to be completed in its Entirety

Date of Referral:_____Referred by: _____

Name: _____

D.O.B.:_____ SS#: _____

Address (please include city / town): _____

Phone:_____Alternative Phone: _____

Name of Guardian:

_____Phone:_____
-

Address of Guardian: _____

Homeless at present: ☒ Yes ☐ No
Living Arrangements: ☐ Lives alone ☐ Lives with family ☐ Lives with non-family

Number of EPC's in the past year:_____Number of ER visits for psychiatric /

substance abuse in past year: _____

Reason: _____

Risk Assessment:
Danger to Self: ☐ Low ☐ Medium ☐ High Danger to Others ☐ Low ☐ Medium ☐ High
History of suicide attempts or other violent behavior: ☐ Yes ☐ No
Explain: Click or tap here to enter text.

Please check all that apply:
☐ There has been a sudden change in status of consumer's substance use (either in terms of frequency, amount, substance of choice, or method)
☐ Consumer has reported recent adverse life experiences that, without treatment will lead to marked decompensation in their current functioning.
☐Consumer has had recent legal involvement
☐ Consumer has reported an increase in mentally unhealthy days leading to a significant change in ability to function
☐ Consumer reported thoughts about self-harm that pose danger to self
☐ Consumer has reported experiencing new, intrusive and imminent suicidal thoughts and / or seeking treatment

Diagnosis defined in words and ICD 10 codes Date of diagnosis

_____ _____

_____ _____

Does the consumer own a pet? ☐ Yes ☐ No ☐ Unknown Type _____
Pets must be controlled by the owner when support worker visits.

Crisis Situation has resulted in (Please check all deficits that apply)

☐ Causing Physical Functioning
☐ Causing Community Living Skills
☐ Causing Vocational / Educational
☐ Causing Personal Care Skills
☐ Causing Mood
☐ Causing Interpersonal Relationships
☐ Causing Psychological State
☐ Daily Living
☐ Causing Social Skills

Referral Source, address, phone and fax number

_____

_____

_____

_____
Signature of Person Making Referral to include credentials Date

---

To be completed by Support Worker Supervisor or designee

Referral Date		Reason Ineligible
Eligible	☐ Yes ☐ No	☐ Age
Assigned ECS Worker		☐ Residence
Date assigned		☐ No Diagnosis
Date of first contact		☐ Safety Concerns
Date Received		☐ Concurrent higher level of care
		☐ Other

Print Name Sign Name Date