Region 1 Behavioral Health Authority
Emergency Community Support
REFERRAL FORM

PLEASE **FAX** to Sue Teal @ 308-632-2326 or email to steal@region1bhs.net

Needs to be completed in its Entirety

SCOTTSBLUFF 18 West 16th Street Scottsbluff, NE 69361
308-635-3173

Date of Referral: _____ **Referred By:** _____

Name: _____

DOB: _____ **SS#:** _____

Address (including city/town): _____

_____

Phone: _____ **Alternate 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 past year: _____ **Number of times in Detox in 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
Explain_____
History of suicide attempt or other violent behavior: ☐ Yes ☐No
***Explain*:** _____

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 experienceing new, intrusive and imminent suicidal thoughts and / or seeking treatment

Diagnosis defined in words and ICD 10 codes **Date of diagnosis:**

_____ _____

_____ _____

Safety concerns that directly relate to how this person will be served by Support Worker:

_____

_____

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 that apply)

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

Agency/ Facility, address, phone and fax number:

_____

_____

_____

_____

Signature of Person Making Referring to include credentials: Date

Approved:☐ Yes ☐ No **(to be completed by Support Worker Supervisor)**

[Completed by Support Worker Supervisor]

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

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Supervisor Signature Date