MHMR of Tarrant County

Crisis Services Referral Form

Case #: ______________________
Name: ______________________
Medicaid #: ______________________

Referred to: ☐ IST ☐ CRU ☐ CARE House

GENERAL INFORMATION			
Client Name:	Client Phone:	Client Location: Community ☐ Hospital ☐	
Home Address:	Current Address:		
Parent/Guardian Name:	Parent/Guardian Phone:		
MHMRTC ID #:	Active Client? ☐ Yes ☐ No	Gender: ☐Male ☐ Female	DOB: SSN:

CONTACT INFORMATION OF REFERRING PERSON *(who completed this form)*		
Name:	Phone:	Email:
Clinic:	Date of Referral:	Date of last assessment:

REASON FOR REFERRAL		
# of Psychiatric Hospitalizations in the past: Year: 6 months:	# Failed Contact Attempts:	Eligible for Furlough? ☐Yes ☐ No

	Diagnostic Impression	Medications	Med Compliant Y/N
Axis I:			
Axis II:			
Axis III:			
Axis IV:			
Axis V:			

Axis IV Chart Below:		
A: Housing	**D:** Problems with Primary Support Group	**G:** Problem Related to the Social Environment
B: Economic Problems	**E:** Occupational Problems	**H:** Problems with Access to Healthcare Services
C: Social Support	**F:** Problems Related to Interaction with Legal System	**I:** Other Psychosocial and Environmental Problems

CURRENT RISK AND SAFETY CONCERNS (CHECK ALL THAT APPLY)

Yes	No		Yes	No	
☐	☐	Current Thoughts of Harming Another Person	☐	☐	Past Thoughts of Harming Another Person
☐	☐	Perpetrator of Violence/Abuse	☐	☐	History of Homicide/Manslaughter
☐	☐	History of Injuring another Person	☐	☐	Victim of Violence/Abuse
☐	☐	Current Thoughts of Self-Harm/Suicide	☐	☐	Past Thoughts of Self-Harm/Suicide
☐	☐	Prior Suicide Attempt (Most Recent Date:)	☐	☐	Recent Trauma Exposure
☐	☐	Current Substance Use/Abuse	☐	☐	Past Substance Use/Abuse
☐	☐	Criminal Justice System Involvement ☐Probation ☐Parole ☐Charges Pending ☐Time Served	☐	☐	Other:

Please e-mail completed form to: Crisis.Services@mhmrtc.org
Please put name of unit referring to in the subject line