NAMI ST. TAMMANY REFERRAL FORM

FOR RESIDENTIAL PLACEMENT

Check One: ☐ **Transitional Group Home** ☐ **Permanent Group Home** ☐ **Apartments**

Client's Name: _____ **DOB:** _____ **Age:** _____

Race: _____ **Gender:** ☐ **Male** ☐ **Female**

Social Security Number _____ **Medicare#** _____ **Medicaid #** _____

Source of Income: _____ **Amount of Income:** _____

Referring Agency: _____ **Contact person's name:** _____

Telephone number: _____ **Fax number:** _____

Reason for Referral to Supportive Housing Program: _____

Client's strengths and needs: _____

Current Diagnosis: _____

_____

Current Medications: _____

_____

Behavioral Concerns:

(check all that apply)

☐ **Non-compliance**	☐ **Suicidal ideation**	☐ **Eating disorder**
☐ **Lying**	☐ **Homicidal ideation**	☐ **Elopement**
☐ **Aggression**	☐ **Criminal activity**	☐ **Psychotic episodes**
☐ **Self Abuse**	☐ **Sexually inappropriate**	☐ **Other:**

Risk:

(check all that apply)

☐ **Currently in a psychiatric hospital**	☐ **At risk for hospitalization**
☐ **Currently homeless/shelter**	☐ **At risk for eviction**

Is the client homeless by HUD's Definition: living in a place not meant for human habitation, in a shelter, losing primary nighttime residence within 14 days and no resources or support to remain in housing, or hotel provided for with a voucher? ☐ **Yes** ☐ **No**

Do you have or are you able to provide proof of homeless status? ☐ **Yes** ☐ **No**

If currently hospitalized has the client been hospitalized greater than 90 days and was homeless prior to inpatient treatment? ☐ **Yes** ☐ **No**

Is the client capable of performing ADL's and providing physical self care? ☐ Yes ☐ No

Is the client willing to comply with medication and mental health treatment? ☐ Yes ☐ No

Does the client have /or is being treated for TB? ☐ Yes ☐ No

Is the client capable of transitioning to independent living within two years? ☐ Yes ☐ No

Is the client interested in becoming employed? ☐ Yes ☐ No

Is the client capable of maintaining a part time job? ☐ Yes ☐ No

Has client been referred to any other housing program? ☐ Yes ☐ No

If denied placement, please state reason for denial: _____

_____

Does the client have a legal history? ☐ Yes ☐ No

If so please specify: _____

_____

Does the client currently have any charges pending? ☐ Yes ☐ No

If so please specify: _____

_____

Has the client received a PRN medication within the past 3 weeks or required restraints or other restrictions/ behavioral interventions? ☐ Yes ☐ No

If so please specify: _____

_____

Does the client have a history of violent/aggressive behavior? ☐ Yes ☐ No

If so when and what was the most recent incident: _____

_____

Does the client have any medical/health needs? ☐ Yes ☐ No

If so please specify: _____

_____

Does the client have any special needs (including dietary) or physical limitations? ☐ Yes ☐ No

If so please identify: _____

_____

Does the client require any special or adaptive equipment? ☐ **Yes** ☐ **No**

If so please specify: _____

_____

Does the client have a history of substance abuse? ☐ **Yes** ☐ **No**

(if so please specify substance and note last known date that substance was used: _____

_____

Please fax or mail referral to:

NAMI ST. TAMMANY

P.O. BOX 2055

MANDEVILLE, LA 70470

FAX # 1-877-361-1631

DO NOT SEND THE INFORMATION BELOW UNTIL REQUESTED

_____

Please forward the following information for further assessment and determination:

☐ **Recent Psychological evaluation** ☐ **History and Physical**

☐ **Social history** ☐ **Progress notes**

☐ **Proof of TB testing** ☐ **Other**