EVA HEALTH SERVICES, LLC.
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REFERRAL FOR SERVICE

DISCLAIMER: Active Medical Assistance is required for PRP Referral and Services. Also, a signature and credentials are required from the licensed clinician who is referring this Consumer. (PLEASE PRINT, SIGN, and DATE)

Please indicate one of the following: _____On-site/Off-site _____ (Off-site Only)

CONSUMER'S IDENTIFICATION INFORMATION

Name: _____ D.O.B. _____/_____/_____ Race: _____

Social Security Number: _____ Sex: _____ Marital Status: _____

Address (including city & state): _____

Home Phone: _____ Cell Phone: _____ Email (optional): _____

Insurance: _____ Policy #:_____

Allergies/Health Concerns:

_____

Highest Level of Education attained:

_____

Does the Consumer have any children? ☐Yes ☐No If YES, how many?_____ Is the consumer a veteran? ☐Yes ☐No

If YES, are they a veteran of: ☐IRAQ ☐AFGHANISTAN ☐OTHER: _____

REASON FOR REFERRAL

Current symptoms/mental health status: _____

_____

_____

What is the consumer expected to gain from PRP services? _____

_____

_____

Check all that apply:

____ Need help with ADL's
____Needs help with medication compliance
____ Needs help with therapy compliance
____ Has poor/severely impaired skills
____ Tends to isolate self
____ Needs help with relapse prevention skills
____ Needs help with coping skills
____ Needs help maintaining stable housing

DIAGNOSIS

Behavioral Diagnosis (AXIS I):_____

Primary Medical Diagnosis (AXIS 3): _____

Social Elements Impacting Diagnosis (AXIS 4): _____

Functional Assessment (AXIS 5):_____

CURRENT MEDICATIONS

NAME OF MEDICATION:	DOSAGE:	(PLEASE CIRCLE PURPOSE FOR MEDICATION)
_____	_____	SOMATIC / PSYCHIATRIC
_____	_____	SOMATIC / PSYCHIATRIC
_____	_____	SOMATIC / PSYCHIATRIC
_____	_____	SOMATIC / PSYCHIATRIC

INPATIENT PSYCHIATRIC TREATMENT HISTORY

Has Consumer ever been admitted for inpatient psychiatric treatment? ☐Yes ☐No If YES, please indicate the approximate number of inpatient psychiatric admissions during lifetime: _____

Please complete the following for the most recent hospitalizations:

Hospital: _____ Admission Date: ___/___/_____Discharge Date: ___/___/_____
Hospital: _____ Admission Date: ___/___/_____Discharge Date: ___/___/_____

DRUG/ALCOHOL HISTORY:

Alcohol? ☐Yes ☐No If YES, please indicate date of most recent use: _____

Other Drugs? ☐Yes ☐No If YES, List substance(s) and Date(s) of most recent use: _____

_____

LEGAL HISTORY

Any current legal issues/concerns? ☐Yes ☐No ☐UNKNOWN If YES, please explain: _____

_____

Previous/Past legal issues? _____

_____

Discuss any history of impulsive, explosive, violent or homicidal behaviors: _____

_____

FAMILY HISTORY OF MENTAL ILLNESS & HISTORY OF TRAUMA:

Mental Illness:

_____

Trauma:

_____

PROVIDER INFORMATION

Treating Psychiatrist: _____ Organization: _____

Address: _____ Phone Number: _____

Mental Health Therapist: _____ Organization: _____

Address: _____ Phone Number: _____

Primary Care Physician: _____ Organization: _____

Address: _____ Phone Number: _____

Referred by: _____ _____ _____

PRINT NAME & CREDENTIALS **SIGNATURE & CREDENTIALS** **DATE**