Southeast Regional Crisis Center
24/7 Mental Health Services
Operated by Nexus Family Healing

Community Referral Form

Date of Referral: _____

DEMOGRAPHICS

Full Name: _____
Nickname: _____
Date of Birth: _____
Gender: _____

Address: _____
Phone: _____ Email: _____

REFERRING ORGANIZATION/PERSON

Contact Person: _____
Agency Address: _____
Phone: _____ Email: _____

INSURANCE INFORMATION (if applicable)

Billing Contact Person: _____
Billing Address: _____
Phone: _____

Medicaid Eligible: _____ Insurance: _____ No Insurance: _____

GRP: _____ PMI: _____ PMAP: _____ ID: _____

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REASONS FOR REFERRAL:
Describe the specific incident(s) or behavior(s) that recently occurred to precipitate the need for this referral and previous behaviors of concern:

_____
_____
_____

Is the individual in agreement with the decision to come to SERCC and possibly receive residential placement? Yes____ No____

Does the individual have:

Active suicidality?	Yes____ No____
A current plan for suicide and the means?	Yes____ No____
If YES, please explain: _____	
Current homicidal thoughts?	Yes____ No____
Agitation that would require restraint?	Yes____ No____
Restraint used in the last 48 hours?	Yes____ No____
Current elopement behavior?	Yes____ No____

SUBSTANCE USE
Current type of substance use
_____

Frequency and duration of use _____ Risk of withdrawal? _____

TRANSPORTATION
Does the individual have transportation or the ability to get to and from SERCC? Yes____ No_____

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PREVIOUS PLACEMENT, PSYCHIATRIC AND OTHER SERVICES (include prior hospitalizations and short-term crisis stabilization utilization for the past 6 months):

_____
_____
_____

YOUTH'S LEGAL GUARDIAN

Name: _____
Address: _____
Phone: _____ Email: _____

Is the Youth's guardian aware the youth is seeking services? Yes _____ No _____

DISCLAIMER: *A youth's guardian needs to be present to admit a youth to residential services at SERCC. No admittance can occur without a guardian present.*

NAMES OF PARENTS, GUARDIANS, AND FAMILY MEMBERS:
Who comprises the youth's "family" (biological, foster/adoptive family, extended family)?

Name	Relationship to Youth

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MEDICAL HISTORY

Are there any current medical issues? Yes____ No____
If YES, please explain/list:_____

Any allergies? Yes____ No____
If YES, please explain/list: _____

Any physical disabilities? Yes____ No____
If YES, please explain/list:_____

Any medical equipment that would need to be utilized on-site? Yes____ No____
If YES, please explain/list:_____
If YES, do they have access to this equipment to bring with them? Yes____ No____

Does the individual have difficulty providing for their own self-care (bathing, feeding, toileting)?
Yes____ No____
If YES, please explain:_____

CURRENT DSM DIAGNOSIS

Code	Diagnosis

Date of last Diagnostic Assessment completed: _____

Has a crisis assessment been completed? __ Yes ___ No
If yes, please send assessment to scc-admin@serccnexus org

CURRENT MEDICATIONS

Medication	Dose

Does the individual have access to the prescribed medications, and can they bring them with in originally prescribed medication bottles? _____

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HISTORY

History of violent behaviors? Yes____ No____
History of self-harm in last 6 months? Yes____ No____
History of elopement? Yes____ No____
If YES, from who and what are the triggers? _____
History of aggression toward family or friends? Yes____ No____
History of aggression toward providers? Yes____ No____
Does the individual have people/populations that trigger an emotional reaction? Yes____ No____
If YES, who are the triggers? _____
History of use to any in-patient or crisis bed? Yes____ No____

Please list any cultural or religious considerations:
_____
_____

Name of person completing this form: _____

Signature: _____ Date: _____

DISCLAIMER: *Verbal Acceptance does not guarantee admittance to residential. Please allow up to 1 hour for an initial response from the Southeast Regional Crisis Center for all referral forms submitted. If a response is needed sooner, please call 507-322-3019 and the Crisis Center will work with you directly. A verbal acceptance of referral results in a bed held for no more than 8 hours. After 8 hours the bed will then be released. We do not provide transportation to or from the Southeast Regional Crisis Center. An acceptance is not a guarantee of admittance. An in-person nursing exam and mental status exam need to be completed at the center to confirm the individual can remain safely at the Crisis Center.*

Please send completed form to ***scc-admin@serccnexus.org***