Southeast Regional Crisis Center
24/7 Mental Health Services

Operated by Nexus Family Healing

Referral Form

Date of Referral: _____

DEMOGRAPHICS

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

REFERRING ORGANIZATION

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:

_____
_____
_____

PREVIOUS PLACEMENT, PSYCHIATRIC AND OTHER SERVICES:

_____
_____
_____

YOUTH'S LEGAL CUSTODIAN
Name: _____
Address: _____
Phone: _____ Email: _____

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

Name	Relationship to Youth

PRIMARY FAMILY LEGAL ADDRESS
Address: _____
Phone: _____ Email: _____

Will the family be a resource and involved in treatment? Yes____ No____

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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:_____

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

LEGAL HISTORY

History of violent behaviors? Yes____ No____
History of self-harm in last 6 months? Yes____ No____
History of elopement? Yes____ No____

Please list any cultural or religious considerations:

_____
_____

Name of person completing this form: _____

Signature: _____ Date: _____