NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH
Community Based Services Referral Form

SERVICE BEING REQUESTED (circle one)			
Crisis Services Coordination	Forensic Case Management	Hospital Diversion (inc CPST)	Partnership for Healthy Aging

CLIENT INFORMATION			
Name *(Last, First, M.I.):*		**Sex**: (circle) M F	**DOB:**
Address:		**Marital status:** ◯ Single ◯ Partnered ◯ Married ◯ Separated ◯ Divorced ◯ Widowed	**Phone** (H):
City:			**Phone** (M):
State:			**Phone** (O):
Zip:			**SSN:**
Lives Alone: Yes No	**If No**, Other in the home:	**Email:***	
Animals in the home:		**Weapons in the home:**	
Primary Insurance:		**Secondary Insurance:**	
Primary Insurance ID:		**Secondary Insurance ID:**	

REFERRAL SOURCE	
Person Making Referral:	**Today's Date:**
Agency:	**Telephone #:**

REASON FOR REFERRAL (Hospital Diversion- CPST Services Requested: ◯)

Presenting Problem:

PREVIOUS INCARCERATIONS/REASONS:

MEDICAL HISTORY

Mental Health Diagnosis:		**Initial Onset:**	
Substance Abuse:		**Medical Problems:**	

PMD – Primary Medical Doctor:

HISTORY OF PREVIOUS TREATMENT

Inpatient Treatment

Inpatient Setting:	Dates:	Reason:	Outcome:

Outpatient Treatment

Clinician:	Dates:	Reason:	Outcome:

Provide client's email if client would like access to Patient Portal

Copy enclosed/ Faxed to 716-278-8130. Attention: Hospital Diversion Program Supervisor Revised 8/2024 ghg

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MEDICATIONS				
Medication:	**M.D. Monitoring**	**Side Effects:**	**Side Effect Severity**	**Note:**

CURRENT LINKAGES/SERVICES				
	Telephone:	Ext.		
Agency:			Court System:	
Therapist:			Attorney:	Telephone:
Psychiatrist:			Parole:	
Care Manager:			Probation:	
SNAP**:** ◯ Yes ◯ No			Task:	
HEAP**:** ◯ Yes ◯ No			Mental Health Court:	
Medicaid**:** ◯ Yes ◯ No	Medicaid ID:		SPOA**:** ◯ Yes ◯ No	Date App. Comp.
Medicare**:** ◯ Yes ◯ No				
SSI/SSDI**:** ◯ Yes ◯ No				

Additional Needs to be Addressed: