NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH
Forensic Case Management Referral Form

REFERRAL SOURCE		
Person Making Referral:	Today's Date:	
Agency:	Telephone #:	
CLIENT INFORMATION		
Name *(Last, First, M.I.)*:	Sex: Male Female	DOB:
Address:	Marital status:	Phone (H):
City:	Single Partnered	Phone (M):
State:	Married Separated	Phone (O):
Zip:	Divorced Widowed	SSN:
Brief Description (to assist in locating or attach picture):		
Alternate Contact Info. (Significant others, family, etc.):		
Primary Insurance:	Secondary Insurance:	
Primary Insurance ID:	Secondary Insurance ID:	
REASON FOR REFERRAL/PRESENTING PROBLEM:		
Expected Jail Release Date:		
Charges/History of Violent Crimes:		
Pending Court Dates/Jurisdictions:		
Risk History:		
Arranged Post Release Appointments/Dates:		
Expected Services Needs Upon Release:		

Copy enclosed/ Faxed to 716-278-8130. Attention: Crisis Service Coordinator

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH
Forensic Case Management Referral Form

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:*

MEDICATIONS(or copy MAR):				
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			AOT:
SSI/SSDI: Yes No			

Other Comments/Notes & Additional Issues to be Addressed:

Copy enclosed/ Faxed to 716-278-8130. Attention: Crisis Service Coordinator