NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH
Hospital Diversion Referral Form

CLIENT INFORMATION			
Name *(Last, First, M.I.):*		**Sex**: ◯ Male ◯ Female	**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:		
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
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:

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

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH
Hospital Diversion Referral Form

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 Issues to be Addressed:

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