

**Harlem Bay Network PROS**

116 E 124th Street, 3rd Floor, New York, NY 10035

Intake Specialist Phone\*: (212) 876-6083 x1012 Fax: (212) 876-6092

**\*Please contact the Intake Specialist by email: pankolekar@mhaofnyc.org**

**PROS Referral Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth & Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_ Veteran: Yes No

Speaks English: Yes No Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_ Religion:\_\_\_\_\_\_\_\_\_\_\_\_

Income Source(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Foodstamps: Yes No

Health Insurance(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/CIN Number :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Education Level/Degree: Literate: Yes No

Employed: Y N  If Yes: Full-time Part Time Per-Diem/Seasonal

Referral Source:

Name/Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROS program use only:**

🞏 Psych Eval/Diagnosis

🞏 Phys Exam

🞏 Psychosocial

🞏 Psych Svc

🞏 Risk – Self-harm

🞏 Risk – Violence

🞏 Risk – Other

🞏 AOT

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROS program use only:**

Date referral received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of intake: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Mental Health Information

Mental Health Information

Current/Most Recent Mental Health Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis (applicant **must have** a primary diagnosis of **a serious mental illness** to qualify for PROS):

DSM5 CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medication (list **medication name, start date of medication**, dosage, and dosing interval):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Health Professional(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will the individual need to receive Psychiatric Clinic services at the PROS program? Yes No

If Yes, how much medication does applicant still have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of ***psychiatric ER*** visits in the last 6 months: \_\_\_\_\_\_\_\_\_\_\_

 12 months:\_\_\_\_\_\_\_\_\_\_\_

 2 years:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of ***psychiatric*** hospitalizations in the last 6 months:\_\_\_\_\_\_\_\_\_\_\_(provide discharge documents)\*

 12 months:\_\_\_\_\_\_\_ (provide discharge documents)\*

 2 years:\_\_\_\_\_\_\_\_\_

Physical Health Information

Does the individual have a Primary Care Physician (PCP): Yes No

If Yes, please list name and contact information of PCP:

Date of last visit to PCP:

Number of ***medical ER*** or ***medical*** hospitalizations in the last 6 months:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Use Information

What type of housing is applicant currently in?

Length of stay at current housing:

Has the applicant ever been homeless? Yes No

If Yes, how many days in the last 6 months has applicant been homeless?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the applicant currently have adult children? Yes No

Does the applicant currently have minor children? Yes No

If Yes, do the minor children reside in applicant’s household? Yes No

If No, does applicant have visitation rights to minor children? Yes No

If yes, please indicate names and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Use Information

Does the individual have alcohol or other substance use history? Yes No

If Yes, list drugs of choice (including tobacco/cigarettes): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last use of alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last use of other substances:

Date of last use of tobacco:

Please list any criminal convictions (please include dates and current status if on parole or probation):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the individual under Parole or Probation Supervision? Yes No

Does the individual have a current AOT court order? Yes No

If Yes, would this PROS program be part of the AOT Treatment/Service Plan upon program admission? Yes\* No \*If Yes, please submit AOT Treatment/Service Plan

Risks for Self-harm or Violence

Risk for self-harm or suicidality (including suicidal ideation) in the last 6 months? Yes No

History of self-harm or suicidality (including suicidal ideation)? Yes No

Current risk level for self-harm or suicidality (circle one): Low Medium High

Risk for violence in the last 6 months? Yes No

History of violence? Yes No

Current risk level for violence (circle one): Low Medium High

Reason(s) for referral to or interest in a PROS program:

Please attach the following **Supporting Documents\*:**

1. Most recent Psychiatric Evaluation containing a primary mental health diagnosis and a Mental Status Exam (within the last 6 months).

2. Most recent Physical Examination (within the last 6 months).

3. Most recent Biopsychosocial Summary (within the last 6 months).

Signature of referral source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**\*Please note: Omission of supporting documents and/or this referral form may delay the applicant’s referral/intake process.**