MHACG
MHA of Columbia-Greene

Personalized Recovery Oriented Services
PROS Referral Form

PARTICIPANT INFORMATION

Date: *

* Designates Required Information

Last Name: * First Name: * Date of Birth: * Social Security #: *

Legal Gender: *
○ Male ○ Female

Gender Identity:

Preferred Pronouns:

Street Address: * City: * State: * Zip: *

Primary Phone: *

Phone Type: *
○ Home ○ Cell ○ Work

Authorized to leave a message: *
○ Yes ○ No

Secondary Phone: *(optional)*

Phone Type:
○ Home ○ Cell ○ Work

Authorized to leave a message:
○ Yes ○ No

Email Address:

Emergency Contact Information:

Last Name: First Name:

Relationship: Contact Phone Number:

Insurance Information:

Medicaid CIN: *

Medicare #:

Medicaid Managed Care #:

REFERRAL NEEDS

Reason for Referral: *

Participant's Strengths: *

Participant's Barriers: *

Special Considerations: *(Trauma, primary health issues, physical or learning disabilities, substance abuse/addictions, medication compliance issues, spirituality, cultural/linguistic, history of violence to self or others, history of suicidality, other)*

HEALTH INFORMATION

Primary DSM 5 Diagnosis Code: *

Description: *

Additional DSM 5 Diagnosis Code(s):

Description(s):

Allergies:

PROVIDERS AND SERVICES

Psychiatrist/NP:

Phone:

Therapist:

Phone:

Primary Care Physician:

Phone:

Other Relevant Provider:

Phone:

Are services currently received from the following: *(Check all that apply)*

- ☐ AOT
- ☐ WillCare
- ☐ Supported Housing
- ☐ Care Coordination
- ☐ CORE Services
- ☐ Peer or Self-Help Services

REFERRAL INFORMATION

Please attach the required documents:

- ☐ Consent form(s) *
- ☐ Psychosocial assessment and/or psychiatric evaluation *

You are welcome to include additional information that you feel would be helpful.

Referring Provider/Agency: *

Name of Person Making Referral: *

Contact Phone Number: *

Email:

Participant Signature *(or authorized rep.)* *

Date *

OFFICE USE ONLY

Date Received:

Notes:

Complete:

◯ Yes ◯ No *(follow up needed)*

Employee Signature

Date

Please email completed forms to pros@mhacg.org or fax to 518.943.6053