REFERRAL DATE:_____

CONDUIT
Together We Can Do It

REFERRAL

CLIENT NAME	*MA #*	*MCO/PCP:*

ADDRESS (# STREET, CITY, & ZIP)	*PHONE(S)*

OTHER CONTACT: *Parent/Guardian for minor- case*	*RELATION TO CONSUMER*	*PHONE(S)*

CLIENT D.O.B	*CLIENT S.S.N.*	*GENDER*	*MINOR*	*VETERAN*	*# OF YRS*	*IF YES, WHICH WAR?*
		☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO		

RACE						*ETHNICITY*	*PRIMARY LANGUAGE*
☐ BLACK	☐ WHITE	☐ BIRACIAL	☐ ASIAN	☐ AM. INDIAN	☐ NAT. HAW/ PACIF.	☐ HISPAN/LATINO?	
RESIDENTIAL ARRANGEMENT							*HURRICANE VICTIM*
☐ PRIVATE HOME	☐ FOSTER HOME	☐ TEMP SHELTER	☐ ASST LIVING	☐ GROUP HOME	☐ RESID. CARE	☐ OTHR/ UNKN	☐ YES ☐ NO — WHICH? (IF KNOWN)
MARITAL STATUS						*IN SCHOOL?*	*HIGHEST GRADE COMPLETE*
☐ SINGLE	☐ MARR	☐ DIVOR	☐ SEPAR	☐ UNKN	☐ MINOR	☐ YES ☐ NO	
EMPLOYMENT STATUS							*PHYSICAL DISABILITY*
☐ FULL-TIME	☐ PART-TIME	☐ UN-EMPLOYED	☐ RETIRED	☐ STUDENT	☐ UNKNOWN	☐ NOT SEEKING	☐ YES ☐ NO — *SPECIFY?*

PRESENTING PROBLEM / CURRENT STRESSORS

CLIENT'S CURRENT REHABILITATION NEEDS (CHECK ALL THAT APPLY)

☐ ALC. ABUSE TX	☐ EDUCATION ASSIST	☐ ENTITLEMENT ACQUISIT.	☐ FINAN. MANAG/ ASST.
☐ HOUSING ASSIST	☐ INDEP. LIV. SKILLS	☐ LEGAL/CUSTODIAL ASSIST	☐ LEISURE /COMMUN. INTER.
☐ MED. MANGMNT	☐ PSYCHOEDUCATION	☐ SAFETY	☐ SELF-CARE SKILLS
☐ SOCIAL SKILLS	☐ SOMATIC TX ASSIST	☐ SUBST. ABUSE TX	☐ TRANSPORTATION
☐ TX COMPLIANCE	☐ VOCAT. SKILLS	☐ OTHER_____ , _____, _____	

CONDUIT INC.◄ 3901 PARK HEIGHTS AVE, BALTIMORE, MARYLAND 21215► FAX 443-759-9063 PHONE 443-869-2680

OTHER NEEDS IDENTIFIED? ***PLEASE IDENTIFY BELOW***

_____

_____

Is client a transition youth age consumer? ___ **YES** ___ **NO** ___**UNKN**

Is client an active participant in therapy at this time? ___ **YES** ___ **NO** ___**UNKN**

Has client been arrested in the last 30 days? ___ **YES** ___ **NO** ___**UNKN**
If yes, # of times:_____

Has client had a psych hospitalization in the last 30 days? ___ **YES** ___ **NO** ___**UNKN**
If yes, # of times:_____

Has client participated in self-help group in last 30 days? ___ **YES** ___ **NO** ___**UNKN**

Does client speak fluent English? ___ **YES** ___ **NO** ___**UNKN**

Does client speak a language other than English at home? ___ **YES** ___ **NO** ___**UNKN**
If yes, language?_____

Is client prescribed psych and/or somatic meds at this time? ___ **YES** ___ **NO** ___**UNKN**

Is the client deaf or do they have serious difficulty hearing? ___ **YES** ___ **NO** ___**UNKN**

Is the client blind or do they serious difficulty seeing? ___ **YES** ___ **NO** ___**UNKN**
even when wearing glasses

Because of physical, mental, or emotional condition, does the client have ___ **YES** ___ **NO** ___**UNKN**
serious difficulty concentrating, remembering, or making decisions (*5 yrs or older*)?

Does the client have difficulty walking or climbing stairs (*5 yrs or older*)? ___ **YES** ___ **NO** ___**UNKN**

Does the client have difficulty dressing and/or bathing? (*5 yrs or older*)? ___ **YES** ___ **NO** ___**UNKN**

Because of physical, mental, or emotional condition, does the client ___ **YES** ___ **NO** ___**UNKN**
have difficulty doing errands alone such as visiting a doctor's office or shopping (*15 yrs or older*)?

DIAGNOSTIC INFORMATION	
ICD 10 #1	
ICD 10 #2	
ICD 10 #3	
ICD 10 #4	
ICD 10 #5 / GAF **OR MEDICAL DX.**	

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CONDUIT
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REFERRAL SOURCE

NAME:_____ **PHONE(S):**_____

REFERRING AGENCY:_____ **REFERRAL DATE:**_____

REFERRING CLINICIAN SIGNATURE & CREDENTIALS:_____

COLLABORATION AGREEMENT

MY PRINTED NAME, SIGNATURE, & CREDENTIALS BELOW INDICATE:

I agree to participate in voluntary collaboration, scheduled & emergency team treatment planning sessions for my referred client(s).

I am aware that in order for my client to receive consistent and uninterrupted Psychiatric Rehabilitation Treatment, my prompt communication and attention to client matters regarding my referred client, including referral request, scheduled treatment sessions, and collaboration with CONDUIT INC. service providers, is required.

CLINICIAN PRINTED NAME:_____ **CREDENTIALS:**_____

CLINICIAN SIGNATURE:_____ **DATE:**_____

*****ATTENTION*****

PLEASE ENSURE THAT YOU HAVE COMPLETED THIS FORM IN ITS ENTIRETY, INCLUDING YOUR PRINTED NAME, SIGNATURE, & CREDEDNTIALS. PLEASE BE SURE TO ATTACH ALL APPLICABLE ACCOMPANYING DOCUMENTS CLIENT HAS AUTHORIZED YOU TO RELEASE INCLUDING:

- ***RECENT PSYCHOLOGICAL & EDUCATIONAL ASSESSMENTS***
- ***RECENT ANNUAL PHYSICAL***
- ***RECENT HOSPITALIZATION DOCUMENTATION***
- ***GUARDIANSHIP DOCUMENTATION***
- ***RECENT TREATMENT PLAN***

ONCE YOU HAVE COMPLETED THIS FORM PLEASE EMAIL/FAX FORM AND ALL APPLICABLE DOCUMENTS TO CONDUIT INC @ Conduitpartners1@gmail.com, OR FAX TO 443-759-9063. CALL US AT 443-869-2680 IF YOU HAVE ANY QUESTIONS.

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