New Perspectives Crisis Residence
1321 Middle Easton Belmont Pike Stroudsburg, PA 18360
Phone: 570-992-7590 Fax: 570-992-2487

Date of Referral: ___________ Time______ New:_____ Readmit: _____ Date of Last Admit________
Name ________________________________ D.O.B.:________ SS#: __________________ Sex______
Physical Address: ____
______________________________ Phone:(H) ______________ (C) __________________
Medical Assistance # ______________ **CCBH** __________ **Other Insurance**:________________
Who does the person live with?____________________________ Can they return there? ***Yes No***
If homeless list discharge location:____
Where are they now?_________________ Phone # where they can be reached: _______________

Referral Person:_____________________________ Referral Source Phone#:__________________
Referral Source Affiliation: ____
Ongoing Caseworker: ___________________ Agency Name: ____________________________
If the person is involved with ICM/CHIPPS, has the ICM been informed about the referral? ***Yes/ No***
Is the person involved with the Office of Mental Retardation? ***Yes/ No***
Our psychiatrist will see the person you are referring and medication adjustments may occur, unless you circle the following: ***No Psychiatric Assessment and Medication Adjustments Necessary.***

Criteria For Entry

Does the person want to come to New Perspectives Crisis Residence?	[ ] Yes	[ ] No
Is the person currently threatening or violent?	[ ] Yes	[ ] No
Has the person acted on thoughts to hurt others?	[ ] Yes	[ ] No
Is the person in need of immediate medical attention?	[ ] Yes	[ ] No
Does the person use/abuse alcohol?	[ ] Yes	[ ] No
Does the person use/abuse street drugs?	[ ] Yes	[ ] No
Does the person use/abuse over-the-counter medications	[ ] Yes	[ ] No

If yes what was used_______________________________ How much ____________________
How often ___________________ Last use___________ When were they last sober?___________
Does the person have a history of DT's? ____
Last seen by MH or Medical Worker (who/when)?

Presenting Problems/Precipitating Factors ____
____
____
____
____
____
____

Does the person report trouble with:

Daily Functioning?	[ ] Yes	[ ] No; Describe	______________________________
Sleeping?	[ ] Yes	[ ] No; Describe	______________________________
Eating?	[ ] Yes	[ ] No; Describe	______________________________
Managing Medication?	[ ] Yes	[ ] No; Describe	______________________________
Relating with Others?	[ ] Yes	[ ] No; Describe	______________________________
Recognizing Danger?	[ ] Yes	[ ] No; Describe	______________________________

 Name ____________

Does the person hear voices/see things? [ ] Yes [ ] No
Describe: ____________
Does the person have command hallucinations currently or by history? [ ] Yes [ ] No
Describe ____________

Present and Past Psychiatric Services
Current Outpatient Services: ____________
Last Psychiatric Inpatient Stay: ____________
Medications (include prescribed and over-the-counter): ____________

Psychiatric Diagnosis: ____________

Additional Information
Does the person smoke? [ ] Yes [ ] No, If Yes, how much? ____________ Education Level ____________
Does the person have access to weapons? [ ] Yes [ ] No
Does the person have thoughts of hurting others? [ ] Yes [ ] No
If so, who? ____________ Does the person have a plan? (Describe): ____________

Has the person hurt anyone in the past? If so, who, and under what circumstances? ____________

Does the person have thought of hurting self or committing suicide? [ ] Yes [ ] No
Has the person acted on those thoughts already? [ ] Yes [ ] No
Does the person have a plan to hurt self? [ ] Yes [ ] No
Describe: ____________
Has the person hurt self in the past? If so, when and how? ____________

Medical History/Needs/Status: ____________

Allergies/Manifestations: ____________

Signature of Person Providing/Taking Referral Info ____________ Date ____________

Please Send Statement of Current Status With This Referral Form.

New Perspectives Staff Only
Date/ Time referral form was received: ____________ Date/ Time all necessary info was received ____________
Accepted to NPCR: **Yes / No** Time: ____________ Verbal Authorization From Delegate **Yes / No** Time: ____________
Authorizing Delegate Name: ____________ # of days authorized: ____________
Will Arrive Via: ____________ Expected Admission Date & Time: ____________
Reason why not accepted: ____________
Referred to Other Service/Other Outcome: ____________

Signature/Title of Person Accepting Individual ____________ Date ____________

Carbon-Monroe-Pike County Officials Use Only

Signature of County Administrator/Delegate ____________ Date ____________