RESTORING DESTINY MENTAL HEALTH SERVICES REFERRAL SCREENING FORM

restoringdestinymentalhealthservices.org

Thank you so much for this referral. In order to have services delivered smoothly and efficiently, this referral form needs to be completed. After this form is completed, it will be reviewed within 5 business days to determine if this patient is appropriate for outpatient mental health treatment with Restoring Destiny Mental Health Services with Jessica T. Fauntleroy, MSW, LCSW-C.

For your convenience, this form can be completed and faxed to Jessica T. Fauntleroy at Restoring Destiny Mental Health Services at (443)478-4707 or emailed to restoringdestinymentalhealth@gmail.com. If you have any questions, please call us at 443-282-8146 or email us. Please attach a copy of the patient's and/or parents ID and medical assistance card.

Patient's Full Legal Name:	Date of Birth:
Current Address:	
Telephone Number/Email Address:	
Social Security Number:	
Medical Assistance Number:	
Place of Employment & Work Schedule:	
Preferred Days & Times for Appointments:	
Parent/Guardian Name and Contact Info:	

School Name and Grade:	Relationship:
Emergency Contact Name:	
Emergency Telephone Number:	

Primary Care Physician or Pediatrician and Date of Last Physical:
Previous Mental Health Provider and Last Date of Treatment:

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Does the patient have a community based case manager? If so, please provide a name, agency & telephone number and email?

Is the patient enrolled in a PRP program? If so, please provide the name of the PRP agency as well as contact person and telephone number and email?

Is the patient enrolled in substance abuse treatment? If so, please provide the name of the treatment agency as well as the contact person and telephone number and email?

Has this patient ever been treated for any mental health diagnosis?

Has this patient ever been hospitalized for mental health related diagnosis? If so, please provide specific information including dates as well as the aftercare plan that took place?

Is the patient currently taking psychiatric medications? Is so, name all medications as well as the psychiatrist or CRNP who prescribed them and when was their last visit?

Does this patient have a history of foster care placement? If so, please provides specifics, including dates?

Are CPS or APS currently involved with this patient? If so, provide specifics regarding the situation including dates and outcomes of investigations?

Has this patient ever been charged with a crime? If so, please provide specifics as well as the outcome of the case?

Is this patient currently on probation or parole? Would therapy be court ordered?

Is the patient in weekly or biweekly sessions? Please name one.

If minor, does patient have an IEP or 504 plan? IF so, please provide specifics as well as information regarding accommodations?