SWVTC RCSC OUTPATIENT REFERRAL REQUEST

SECTION I: **Case Manager to complete**: **Please complete ALL items putting N/A where applicable.**

CLIENT NAME:______________________________________ SS #: __________________________
(FIRST) (MIDDLE) (LAST)

CLIENT ADDRESS: ____
Number/Street or P.0. Box

____
City/Town State Zip Code Phone

BIRTH DATE_______ AGE:__ _____ SEX: M F (circle) MR Level (circle) Profound Severe Moderate Mild

CSB:_________________________ CASE MANAGER:______________________ PHONE ___________

RESIDENTIAL PROVIDER: ________________________CONTACT _______________PHONE ___________

EMERGENCY
CONTACT____PHONE____________

IMMEDIATE FAMILY MEMBER ____

ADDRESS____ PHONE ___________
Number/Street or P.O. Box City State Zip Code

VOC PROVIDER: _____________________CONTACT:______________________PHONE ____________

BEHAVIOR PROGRAM SPECIALIST:_____________________________________ PHONE____________

SERVICES REQUESTED:

____
____
____

CLIENT INFORMATION:

MEDICAL DIAGNOSIS:____
____

PRESCRIBED MEDICATION: ____
____

CAPABILITIES: (CIRCLE THOSE THAT APPLY)

a. Ambulatory: Yes No Use: Wheelchair Walker Other

b. Communication: Non-verbal Gestures Manual Signing Vocalizations Verbal

c. Sensory Impairments: Partially Deaf Deaf Partially Blind Blind

d. ADL"s: Total staff assistance Mostly staff assistance Minimal staff assistance Independent

COMPLETED BY:________________________________ Date:

CSB COORDINATOR:_____________________________ Date:

When completed Fax to: SWVTC at (276) 728-1103; Attention: Karen Poe, RCSC Referral

SECTION II: SWVTC STAFF TO COMPLETE:

Date Referral Received:__________ Former RCSC Client? Y or N Former SWVTC Resident? Y or N

Presenting Problem:

Reason for Referral:

History:

Behavioral issues:

Psychiatric issues:

COMPLETED BY:________________________ Date:

SECTION III

Forms Required (check all that apply) | Date Received

Patient Registration Consent
Current Physical
Consent for Medical/Surgical
Or Dental Treatment
Consent to Exchange Info
Medical Hx Questionnaire
Psychiatric Report
Physician Order (PT only)

SECTION IV

1)Referred to:________________________ What Service:

2)Comments:

3)Reason Why Services Not Provided:

COMPLETED BY:________________________ Date:

SECTION V

Follow-up on dental services:

Call made to ensure no new medical problems have occurred in the last five days before the scheduled appointment.
Name of person spoken with about the patient and relationship to the patient.
____

COMPLETED BY:__________________________ Date: