Homeostasis
Home Care

300 Third Avenue
Asbury Park, NJ 07712
P: (908) 251-4194
F: (908) 573-5564

REFERRAL PACKAGE

Please ensure all areas of the referral forms are completed in full. Missing information will delay the process. We require:

- ✓ Referral Information Form (Referral Source or Self-Referral);
- ✓ Full Current Medication List;
- ✓ Consent to Release of Information;
- ✓ If hospitalized within the last 30 days please provide hospitalization in-take forms;
  ✓ **One** (1) piece of picture identification or a letter of identification from a professional or service agency before admission to Homeostasis Home Care.
  ✓ Health Insurance Card
  ✓ Proof of Income (i.e. Award Letter, Bank Statement, etc.)

Thank you for considering Homeostasis Home Care. If you have further inquiries regarding our intake procedure, please do not hesitate to call.

REFERRAL INFORMATION FORM

COMPREHENSIVE INTAKE

Name of Client: _____ Date: _____

Social Security #: _____ DOB: _____

Estimated Date of Arrival: _____

Name of referring AGENCY: _____

Address: _____

City: _____ ZIP: _____

Email Address: _____

Name of REFERRAL WORKER: _____

Telephone: _____

Fax: _____

Current Physician: _____ Telephone #: _____

In Case of Emergency Contact: _____

Relationship: _____

Emergency Contact Address: _____

Emergency Contact Telephone #: _____

Health Insurance Information: (Member ID #, Plan Type, Etc.)

Please provide a photo copy of Health Insurance Card

Health:

Diabetes ☐ Yes ☐ No Epilepsy ☐ Yes ☐ No

Other conditions:(i.e. HIV, STDs, HEP A/B/C, TB) ☐ Yes ☐ No if yes, please list below:

Allergies ☐ Yes ☐ No

If yes, please list (food, medication, environmental)

CLIENT'S History of In-Patient Psychiatric Care:

Previously Hospitalized? ☐ Yes ☐ No

Within the last 30 days? ☐ Yes ☐ No

*** If within the last 30-days - Please provide hospital in-take forms***

Has client had extended medical treatment? Note any previous diagnosis or referrals for diagnosis:

special diet indicated? ☐ Yes ☐ No _____

Mental Health Condition Presented:

Please provide details: (date of diagnosis/conditions, current status, reason for seeking services)

Please provide a full/current medication list as a part of your completed package

CLIENT CURRENT STATUS:

Comments:

Details:

: ☐ Immediate Family ☐ With Parents ☐ Alone ☐ With Ex

tended Family ☐ With Children ☐ With Friends

☐ Other: (Shelter, Detox, Transition House, Homeless, Recovery Home)

_____

☐ Single ☐ Married ☐ Divorced☐

CLIENT EDUCATION

Highest Level of Education Completed: _____

Trade/Technical Courses/Other Achievements:

Other

Please list languages: _____

Literacy Skills - Do you require assistance for reading and writing?

Other Educational Related Information:

English Language spoken by the client: ☐ Yes ☐ No Written: ☐ Yes ☐ No

If no, please list primary language: _____

CLIENT'S SOURCE OF INCOME

☐ SSI/SSD (please include award letter) ☐ Employment ☐ Family/Relative

☐ Disability/Worker's Compensation ☐ Pension ☐ Unemployment

☐ Other: _____

Client's gross monthly income: _____

***if client has a PAYEE please list:**

Name: _____

Contact information: _____

Relationship to Client: _____

EMPLOYMENT

If Employed: Date of most recent employment: _____

Position: _____

Where: _____

Length of Employment: _____

ADDITIONAL RELATED INFORMATION

Are there any Vision/Dental needs?

If yes, please describe:

List skills, hobbies, interests, strengths, accomplishments the client is proud of:

immediate family? ☐ Yes ☐ No

Are there conditions we need to be aware of? ☐ Yes ☐ No

We, the undersigned, agree that the information provided on this Referral Form is true and accurate to the best of our ability.

Signature of Worker: _____

Date: _____

Signature of Client: _____

Date: _____

Fax completed Referral Package to:

Confidential line @ (908) 573-5564