Abbe Center Community Based Recovery Services(CBRS) Referral Form

Referral to:				
___Community Support	Jean Wyant	319-365-9109	fax 319-365-9118	jwyant@abbe.org
___ Home-based Psych Nursing	Jean Wyant	319-365-9109	fax 319-365-9118	jwyant@abbe.org
___PACT	Theresa Graham-Mineart	319-294-4930	fax 319-365-9118	tmineart@abbe.org
___Transitional Living Service (onsite)	Carmen Johnson	319-286-9822	fax 319-390-0724	cjohnson@abbe.org
___Transitional Living Service (offsite)	Carmen Johnson	319-286-9822	fax 319-390-0724	cjohnson@abbe.org
___Adult Day Tx ___Club 520 Wellness Center	Cheryl Schatzle	319-398-3562	fax 319-398-3501	cschatzle@abbe.org
___Life Skills ___IPR	Cheryl Schatzle	319-398-3562	fax 319-398-3501	cschatzle@abbe.org
___ Integrated Health Home (primary care)	Megan Vranish	319-261-0576	fax 319-261-0583	mvranish@abbe.org
___Integrated Health Home (Care Coordination)	Megan Vranish	319-261-0576	fax 319-261-0583	mvranish@abbe.org

Name_____ DOB_____SS# _____-____-_____Phone_____

Address_____
Street city state zip code

County of legal settlement _____ Income Type _____Income/Benefits amount:_____

Medicaid # _____ Medicare #_____ A B D (circle) Other funding: _____

Treatment Team Members:

Med Prescriber_____ Therapist _____
Case Manager_____ Nurse _____
Vocational_____ Sub Abuse_____
In-Home staff_____ Family Dr _____
Prob Officer _____ Attorney _____
Advocate _____ Natural Support _____
Payee _____ Other _____

Diagnosis: _____

Reason for referral (Assessed Needs/Client Stated Goals):_____

_____

_____

_____

_____

Please Circle Indentified Needs:	Access Resources	Crisis Intervention
Develop/Maintain Daily Routine	Housing	Illness Education
Transportation	Independent Living	Interpersonal Skills
Case Coordination	Medication Compliance	Physical Health
Substance Use (Avoidance/Reduction)	Support to Family/Friends	Symptom Mgmt
Advocacy / Apply for Benefits	Develop Natural Supports	Assist with Legal Issues

Has individual had 2 or more psychiatric hospitalizations in their lifetime? When/Where: _____

_____

Means of transportation: _____Mental Health Commitment Yes-or-No. If Yes What County_____

Person making Referral: _____Phone_____Date_____

The following information is **needed** in order to process this referral. If available, please attach the following:

_____Psychiatric Evaluation (with all 5 Axis) _____Social History ____List of Current Medications
_____Copies of any legal papers (i.e. guardianship, commitment, probation…)
_____Copy of Funding Request submitted (double check with Team Leader if funding is needed at time of referral)

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For Office Use: