Project180-Chicago
1507 East 53rd St., Unit 247, Chicago, IL 60615
Phone: (312) 620-2410 Fax: (973) 481-0195
E-mail: info@project180chicago.com

REFERRAL PACKET

Thank you for your interest in Project180-Chicago. We provide residential treatment suites for persons with mental physical disabilities and substance use disorder. Our homes range from transitional to long-term and provide services to those in immediate of need.

Please review the following criteria prior to completing the attached referral form. Project180-Chicago does not discriminate based on race, creed, color, age, ethnicity, religion, gender, sexual orientation or national origin in either the eligibility or intake process.

Inclusionary Criteria:

Individuals wishing to apply for Residential Suites must:

1. Have a mental illness diagnosed on Axis I (DSM-IV), such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder or Major Depression or Substance Abuse.
2. Be 18 years of age or older.
3. Demonstrate sufficient psychiatric stability such that he/she does not require inpatient services.
4. For a referral made to the 450/MICA and 324/IRP programs individuals referred from a state hospital with a minimum of a four-month length of stay will be given priority. Our other residences can take referrals from the community.
5. Be a US citizen.

Exclusionary Criteria:

1. Persons with Axis I (DSM-IV) diagnoses of Substance Abuse (without a concurrent primary diagnosis as indicated in item 1 on the inclusionary criteria).
2. Symptoms and/or behavior that present a danger to self, others, or property.
3. Persons with a history of arson, homicide, attempted homicide, or patterns of violent behavior, including sexual assault/molestation will be assessed as to the clinical appropriateness of the referral
4. If referral for SA/SUD, clean time of less than 90 days.
5. Persons with medical conditions requiring skilled nursing care.

Once your completed referral packet is received, it will be thoroughly reviewed. You will be contacted as to its disposition within three working days.

Once again, thank you for your interest in Project180-Chicago.

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REFERRAL SOURCE: Date of Referral:___________________

Contact Person: ____ Date: _____________________

Referring Agency (if applicable): _________________________________ Phone: ( ) ________________

Relationship to Client: ____ Fax: ( ) ________________

Address: _____________________________ City: ___________________ State: _______ Zip: ___________

CLIENT INFORMATION:

Client Name: ____ Phone#: __________________________

Address: _____________________________ City: ___________________ State: _______ Zip: ___________

D.O.B.: __________________ Social Security #: ______-_______-_______ Sex: ( ) Male ( ) Female

Does client have any children? ( ) Yes ( ) No If yes, how many children? ____________

Race/Ethnicity:
( ) American Indian or Alaskan Native
( ) Asian or Pacific Islander
( ) Black, Not of Hispanic Origin
( ) Hispanic
( ) White, Not of Hispanic Origin
( ) Other: ______________________

Primary Lang:
( ) English
( ) Spanish
( ) American Sign Language
( ) Other: ______________________

Marital Status:
( ) Married
( ) Widowed
( ) Divorced
( ) Separated
( ) Never Married
( ) Unknown

Veteran:
( ) Yes
( ) No

Religion: ____________________

COMMUNITY CONTACTS:

Name: _________________________ Relationship: __________________ Phone: ( ) _________________

Address: _____________________________ City: ___________________ State: _______ Zip: ___________

Name: _________________________ Relationship: __________________ Phone: ( ) _________________

Address: _____________________________ City: ___________________ State: _______ Zip: ___________

DIAGNOSIS (DSM IV):

Axis I: ____ DSM Code: _______________

Axis II: ____ DSM Code: _______________

Axis III: ____ DSM Code: _______________

Axis IV: ____ DSM Code: _______________

Axis V(GAF): ____ DSM Code: _______________

REFERRAL FORM

Describe presenting illness. ____

____

____

MEDICATION HISTORY:

Medication	Dosage	Frequency	Physician	Date Prescribed	Date Stopped

HISTORY OF ILLNESS:

List previous hospitalizations.

Name of Hospital	Reason for Admission	Admission Date	Discharge Date

Describe indicators of decompensation. ____

____

____

Has client ever been involved in outpatient/partial care treatment? ( ) Yes ( ) No If yes, explain:

Name of Facility	Dates of Attendance

REFERRAL FORM

Is there a history of suicide attempts/gestures/ideations? (   ) Yes   (   ) No   If yes, explain:

____

____

____

Is there a history of violent/assaultive behavior? (   ) Yes   (   ) No   If yes, explain:

____

____

____

Is there a history of fire setting? (   ) Yes   (   ) No   If yes, explain:

____

____

____

SUBSTANCE USE HISTORY:

Does client have history of alcohol or drug use? (   ) Yes   (   ) No   If yes, explain:

Substance(s)	Date of First Use	Amt./Freq. of Use	Date of Last Use

What was the client's longest period of abstinence? ____

Has client ever been in treatment for substance use? (   ) Yes   (   ) No   If yes, explain:

Type of Treatment (IP, OP, Rehab, Residential, etc.)	Admission Date	Discharge Date

REFERRAL FORM

Has client participated in self-help/support groups? ( ) Yes ( ) No If yes, explain:

Type of Group	Attended (Y/N)	Last Date Attended	Frequency of Attendance
Alcoholics Anon.			
Narcotics Anon.			
MICA			
Other (specify)			

HEALTH CONCERNS/CURRENT HEALTH ISSUES:

Has client ever been treated for any of the following? Check all that apply and explain below.

( ) Allergies
( ) Blood Pressure
( ) Cancer
( ) Diabetes
( ) Eating Disorders
( ) Gait/Balance Problems
( ) Gynecological Problems
( ) Hearing Problems
( ) Heart Disease
    ( ) Heart Attack
    ( ) Endocarditis
    ( ) Other: _________________
( ) Hepatitis A, B, or C

( ) Hyponeutremia
( ) Kidney Disease
( ) Liver Disease
( ) Muscular/Skeletal Problems
( ) Pancreatitis
( ) Respiratory Problems
( ) Seizure Disorder
( ) Sexually Transmitted Diseases
( ) Sleep Problems
( ) Thyroid Problems
( ) Tuberculosis
( ) Ulcer
( ) Vision Problems
Other: _________________

If any medical conditions are noted above, describe treatment of existing medical conditions.

Are there any restrictions on daily activity? ( ) Yes ( ) No If yes, explain:

REFERRAL FORM

When was the client last tested for Tuberculosis? What were the results?

____

____

When was the client last tested for Hepatitis? What were the results?

____

____

Has client undergone any surgery? (   ) Yes   (   ) No   If yes, explain:

____

____

Is client prone to falls or accidents? (   ) Yes   (   ) No   If yes, explain:

____

____

History of Abuse:

(   ) Physical
(   ) Sexual
(   ) Emotional
(   ) Domestic

If yes, explain: ____

____

____

EDUCATION:

Can client read? (   ) Yes (   ) No   If yes, what language(s)? ______________________

Can client write? (   ) Yes (   ) No   If yes, what language(s)? ______________________

Can client do simple math? (   ) Yes (   ) No

What is the highest grade/level completed? ______________________________________

Has client attended special classes (e.g.: math, english, learning disabled)? (   ) Yes (   ) No   If yes, explain:

____

Has client had any trade or technical training? (   ) Yes (   ) No   If yes, explain:

____

LEGAL STATUS:

Has client ever been involved in the legal system? (   ) Yes (   ) No   If yes, explain:

Describe Charge/Involvement	Date of Charge/Involvement	Current Status

REFERRAL FORM

ECONOMIC RESOURCES:

Does client have an employment history? ( ) Yes ( ) No If yes, explain:

Type of Job	Dates of Employment	Salary	Reason for Leaving

Does client receive any of the following assistance? ( ) Yes ( ) No If yes, explain:

Type of Assistance	Currently Receiving	Amount	Application Date
SSI			
SSD			
Public Assistance			
Food Stamps			
Other			

Does client receive Medicaid? ( ) Yes ( ) No Medicaid #: ___________________________

Does client receive Medicare? ( ) Yes ( ) No Medicare #: ___________________________

Does client have other insurance? ( ) Yes ( ) No

Name of insurance company: _________________________________ Identification Number: ___________________

LIVING ARRANGEMENTS:

Describe client's living arrangements over the past 5 years (e.g., apartment, group/boarding home, with family).

Placement	Length of Stay	Reason for Leaving

REFERRAL FORM

ACTIVITIES OF DAILY LIVING (ADL) SKILLS:

Please rate client's performance in the following areas by placing a checkmark in the appropriate space.

Skill/Task	Performs Independently	Needs Reminders	Needs Hands-On Assistance	Unable to Perform	Unable to Assess
Eating					
Cooking					
Hygiene/Grooming					
Cleaning					
Laundry					
Budgeting					
Shopping					
Public Transportation					
Self-Medication					
Use of Leisure Time					
Socializing					
Accessing Resources					

Please include the following documentation with this application:

Copy of Social Security Card
Copy of Birth Certificate
Copy of Current Award Letter
Proof of Income (if applicable)

Additional Information Required:

1. Copy of initial psychiatric evaluation
2. Copy of most recent psychiatric evaluation
3. Copy of initial (admission) psychosocial assessment and annual/(re-admission) assessments (if applicable)
4. Copy of most recent treatment plan
5. Copy of most recent physical examination
6. Copy of discharge summaries of previous admissions
7. Copy of most recent substance abuse assessment
8. Copy of case review/treatment team notes

____ Phone: (   ) _________________

Name of Referral Source

____ __________________________

Signature of Referral Source Date

Please send completed information to: Project180-Chicago via mail or email