A.I.D. SOCIAL SERVICE AGENCY/ FACILITY AND HOSPIAL REFERRAL FORM

REFERRAL REPRESENTATIVE_____

REFERRING AGENCY/ FACILITY_____

NAME OF SOCIAL WORKER/ DISCHARGE PLANNER_____

PHONE#_____ FAX#_____

PATIENT NAME_____

PATIENT ADDRESS_____

CITY_____ ZIP_____ DOB_____ DOD_____

INSURANCE_____

SS#_____ PHONE#_____

INSURANCE ID_____ GROUP#_____

INSURANCE PHONE#_____

LOC
IOP_____ THERAPY_____ PSYCHIATRIST_____

(PLEASE PROVIDE CODES)
AXIS I_____, _____, _____

AXIS II_____, _____

AXIS III_____

AXIS IV_____

AXIS V _____

BRIEF SUMMARY FOR REFERRAL (BE SPECIFIC FOR BEHAVIOR OF PAST 3 DAYS)
_____
_____
_____
_____
_____
_____
_____
_____
_____

PASSIVE SUICIDAL IDEATIONS? _____ EDO? _____ PASSIVE HOMICIDAL IDEATION? _____

PSYCHOSIS? _____ PARANOIA? _____ MANIA? _____

PLEASE FAX TO 404.393.6439 AND INCLUDE THE FOLLOWING: MEDICATION LIST, COPY OF INSURANCE CARD, LIST OF OUTPATIENT PROVIDERS SUCH AS PCP/ PSYCHIATRIST IS APPICABLE. A REPRESENTATIVE WILL CALL WITHIN 4 HOURS OF REFFERAL.