Homebound - POSITIVE SOLUTIONS

A program of Union of Pan Asian Communities

REFERRAL FORM

Please email this form to yesquivel@upacsd.com Attn: Program Manager or, **Today's date:**

Call us at 619-481-2652 with the following information to make the referral.

Services are provided via telehealth.

***Required Fields.**

IS THE INDIVIDUAL:

***At least 60 years old?** ☐ YES ☐ NO

***Homebound or socially isolated?** ☐ YES ☐ NO

***Depressed, overwhelmed or at risk?** ☐ YES ☐ NO

***Having suicidal thoughts, homicidal thoughts or in crisis?** ☐ YES ☐ NO

***Showing signs of dementia or any other type of cognitive impairments?** ☐ YES ☐ NO

If yes, please describe what is observed:

Having a psychotic episode? (Hallucinations, bizarre thoughts, etc.) ☐ YES ☐ NO

*Currently receiving mental health services? ☐ YES ☐ NO

If yes, please provide name and type of service provider:

CONTACT INFORMATION FOR OLDER ADULT:

*Last Name: *Name: *Address: *City: *Zip Code:

*Phone Number: *Language(s): *Monolingual? ☐ YES ☐ NO

*Gender: *DOB: Age: Preferred Call Times:

Trusted Emergency Contact (if applicable): Relation: *Phone #:

REFERRING PARTY INFORMATION

Self-Referral/Referring Party: Phone Number:

CLINICAL INFORMATION

*Individual's report of problems/goals:

Psychotropic medications?

Case management issues:

Safety issues (pets, odors, environment):

Significant life events and physical limitations (specific dates):

History of Addiction/Substance Use? ☐ UNKNOWN ☐ NO ☐ YES If Yes, approximate date of last use:

Substance(s) of Choice:

History of Treatment(s) for Drug/Alcohol or Co-Occurring issues:

Risk factors: (gambling, suicide attempts, SI, HI, command AH, property damage, threats, risky behaviors):

Person Completing Referral: Title: Date:

PSP Office Use Only

Client #

For Internal Use Only

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