

POTOMAC CASE MANAGEMENT SERVICES, INC.

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Hagerstown, MD 21740

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Case Management Consumer Referral Form

Consumer _____ Referral Date _____

Address _____

Phone _____ DOB _____

SS# _____ Sex _____ Race _____ Marital Status _____

Has this consumer received case management services at PCMS? _____

Please check all areas of need for this consumer:

- | | |
|------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Housing | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Entitlements | <input type="checkbox"/> Daily Living Activities |
| <input type="checkbox"/> Compliance with Mental Health treatment | <input type="checkbox"/> Primary Support system/group |
| <input type="checkbox"/> Employment/ Education | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Financial | _____ |
| | _____ |

Diagnosis: Please list the ICD-9 Codes along with Diagnosis

Axis I _____

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V GAF Score _____ Date of evaluation: _____

Name of evaluator: _____

Current Medications and Dosages: _____

History of Legal Information: _____

History of In-patient hospitalizations:

Date: _____ Facility: _____

Date: _____ Facility: _____

Date: _____ Facility: _____

Date: _____ Facility: _____

Date: _____ Facility: _____

Date: _____ Facility: _____

Current Sources of Support:

Medicare #: _____

Medicaid #: _____

Other: _____

Emergency Information: (For persons under 18 list a second person other than legal guardian)

Contact person and number: _____

Contact person and number: _____

Other Information relevant to clients needs: _____

Referral Source:

Name: _____ Agency: _____

Phone Number: _____

PCMS USE ONLY: Date Received: _____ Reviewed by: _____