POTOMAC CASE MANAGEMENT SERVICES, INC.

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Telephone: 301-791-3087 Fax: 301-393-0730

Case Management Client Referral Form

Client Name Referral Date

Address

Phone DOB

SS# Sex Race Marital Status

Has this client received case management services at PCMS?

Is client a veteran?____N____Y

If so, what wars?____

Current Sources of Support:

Medicaid #: PAC:

Medicare #: Medicaid /PAC Application Submitted____N____Y

Date____/___/______

If uninsured, monthly income___________________source of income_________________________

Please check all areas of need for this client:

Housing

Legal

Entitlements

Daily Living Activities

Compliance with Mental Health treatment

Primary Support system/group

Employment/ Education

Other: ____________

Financial

____

Diagnosis: Please list the DSM-IV Codes along with Diagnosis

	Code	**Diagnosis**
Axis I		
Axis II		
Axis III		
Axis IV		
GAF Score		
Eval Date	/ /	**Evaluator Name:**

Current Medications and Dosages:

Medication	Dose	Frequency

Recent incarceration ____N____Y. If so, release date___/___/_____.

History of Legal Information:

History of In-patient hospitalizations:

Date: Facility:

Date: Facility:

Date: Facility:

Date: Facility:

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: