**:**

**Client Information**

**Name**: Last      First      **Gender:**  **M**  **F**  **T** **DOB**

**Phone**      **Address (if applicable):**

**Current Case Manager/Staff Involved:**       **Phone:**

**Current Diagnosis (Please include all applicable diagnoses):**

**Date of Referral:**        **Referral Party Name/Agency:**

**Is Individual aware and/or supportive of respite referral:** Y N

**Briefly explain why the individual needs respite services:**

**Check all applicable factors below:**

**Suicidal Ideation** **Self- Abuse or Mutilation**  **Inappropriate Sexual Behavior**

**Chronically Homeless** **Recently released from jail or prison** **Danger to self or others**

**Aggressive behavior** **Hallucinations** **Substance Abuse**

**Frequently admitted to a psychiatric inpatient facility, stabilization unit, or ER visits for psychiatric care**

**Transitioning or recent discharge from psychiatric inpatient setting**

**Individual free of medical issues that require daily nursing or physician care**

**Individual is able to safely remain in an open, community based placement**

**Individual demonstrates need for short-term support which could mitigate the need for higher level of service**

**Individual has a circumstance which destabilizes their current living arrangement and the provision of this service would provide short-term crisis relief and support**

**Does the client have income? Y N Has the client applied for disability? Y N**

**Has the client applied for the Georgia Housing Voucher? Y N**

**Is returning to a previous residence a possibility for the client? Y N**

Current Medications and Allergies:

Referring Party Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_