**:**

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_