RESIDENTIAL CRISIS SERVICES OF
GARRETT COUNTY LIGHTHOUSE, INC.
P.O. BOX 116
OAKLAND, MD 21550
Lighthouse: (301) 334-9126/ Fax: (301) 334-8894
Safe Harbor: (301) 334-1642
Compass House: (240) 362-7082/ Fax: (240) 362-7085

REFERRAL FOR RESPITE SERVICES
ALL INFORMATION ON REFERRAL IS REQUIRED AND MUST BE COMPLETED (PLEASE TYPE)

Date: _____

Name: _____ Date of Birth: _____

Address: _____ Birthplace: _____

_____

Telephone #: _____ Race: _____ Gender: M____ F_____

Social Security #: _____ Marital Status: _____

Transportation: _____ Highest Level of Education: _____

Medical Assistance # _____ Gray Zone: _____

Medicare # _____

Medical Insurance: _____ Policy # _____

Psychiatric Diagnosis: (PLEASE INCLUDE F CODE)

_____

_____

_____

_____

_____

_____

Diagnosed by: _____ Date of diagnosis _____

Psychiatrist: _____ Therapist: _____

Is the client currently involved in a structured day program? _____ Yes _____ No

Name of program: _____

Contact person: _____

Others involved in Treatment/Rehabilitation (i.e. NA, Parole/Probation/Addiction Services)

_____

_____

Psychiatric Hospitalizations: _____

_____

Psychiatric medication monitoring: _____ Yes _____ No

Referral for Respite Services (CONTINUED)
Name: _____

Medications Dosage Prescribed By:

_____
_____
_____

Medical Conditions/Limitations/Allergies:

_____
_____
_____

Date of Last Physical: _____ Physician: _____
Address: _____
Phone: _____

Risk Assessment:

Suicidality: _____ Ideation: _____ Plan: _____ Prior Attempts (if known): _____
_____
_____Other Risk Behavior: _____
_____Substance Abuse: _____

Recommended Service Needs:

_____
_____
_____

Is Respite Care needed

a) at a specific future time _____ d) In-home _____
b) Immediately _____ e) Out-of-home _____
c) Intermittently _____ f) 1:1 supervision _____

Expected Duration of Respite Care:

From: _____ To: _____

Frequency, level and type of staff contacts needed:

_____
_____

Referral Source (Name of agency. Mental health professional or individual):

_____

Signature of Referral Source: _____

Physician's Signature _____ Date: _____

Please Print Physician's Name: _____

Patient's Signature: _____

VALUE OPTIONS Authorization for services

ASP Care Manager (full name): _____

Initial level of care approved:

Procedure
_____ H0045 Respite Services, full day

Date Range _____ to _____ Authorization # _____