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 / Fax: (301) 750-7307
Compass House: (240) 362-7082/ Fax: (240) 362 7085

REFERRAL FOR RESPITE SERVICES
ALL INFORMATION ON REFERRAL IS REQUIRED AND MUST BE COMPLETED

Name: _____ Date: _____

Address: _____

_____ Telephone: _____

Date of Birth _____ Social Security # _____ Gender _____Race _____

Education: _____ Below 12th grade _____ GED _____ High School Diploma _____ College

Employment: _____

Emergency Contact: _____ Telephone: _____

Current living arrangement: _____

Marital Status: _____ Dependent Children: _____ # in Family: _____

SSI _____ SSDI _____ Food Stamps _____

Other Income: _____ Fee Basis: _____Yes _____No

Veteran: _____Yes _____No VA income _____ VA Medical Benefits _____

Medical Assistance # _____ Medicare # _____

QMB: _____Yes _____No

Other Medical Insurance: _____ Policy # _____

Other Payment Sources: _____

Psychiatric Diagnosis:

B. Diagnostic Information: (BE SURE TO INCLUDE F CODE PLEASE)

_____

_____

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
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) 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 # _____