Re-Entry Referral Form

(Use only if form is not available on Scribe)

Date of Referral: ____ (Provide 30 days notice when possible.)

Offender's Name/AKA: _____________________________________/___________________________________
(Name on prison record) (Alias or "real" name if different)

GDC ID#: _______________________________________ SSN: ____

Race: ______ Sex: ______ Date of Birth: _______________________ Release Date:___________________
(Use racial codes: W=White B=Black H=Hispanic A=Asian I=Native American/Native Hawaiian U=Unknown/All Others)

Type of Release: [ ] Sentence Expired, No Probation. [ ] Parole/Reprieve
[ ] Split sentence, Probation Follow Parole. [ ] Probation Only

____ Level of Care: ______________
Chief Probation/Parole Officer

Is the Offender "At Risk" for homelessness after release? [ ] Yes [ ] No

Residence Plan: [ ] Own Home/Apartment [ ] With Relative [ ] Shelter [ ] Homeless

Emergency Contact for Consumer: __________________________________ Contact Phone: ________________

Offender Address: ____

Offender Phone: _________________________________ Alternate Phone: ________________________________

Mental Health Diagnosis: Principal Diagnosis: ____

Other Diagnosis: ____

Other Diagnosis: ____

Mental Health Medication: ____ Dosage: ____________________

Mental Health Medication: ____ Dosage: ____________________

Mental Health Medication: ____ Dosage: ____________________

Mental Health Medication: ____ Dosage: ____________________
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Physical Health Diagnosis: [Note: The offender must sign a consent for the release of the physical health information.]

[ ] Yes (specify):____

[ ] None [ ] Release of Physical Information Refused by Client.

Retention Schedule: Completed forms shall be given to the offender (original), a copy placed in the offender's mental health file (section 7) and fax (if not completed on Scribe) to Probation Officer/Parole Officer and Department of Community Supervision (DCS). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.

Physical Medication: ____ Dosage: ___________________

Physical Medication: ____ Dosage: ___________________

Medical Appliances Required: [ ] None [ ] Wheelchair [ ] Crutches [ ] Braces [ ] CPAP [ ] TENS
[ ] Other (specify):____

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Major Offense: ____

-Description of Significant Problems or Behaviors when **on Medication:**
[ ] None [ ] Injurious to Self [ ] Threatening/Injurious to Staff/Peers

-Description of Significant Problems or Behaviors When **Not on Medication**:
[ ] None [ ] Injurious to Self [ ] Threatening/Injurious to Staff/Peers

-History of Suicidal Ideation: [ ] Yes [ ] No Suicide Attempts [ ] Yes [ ] No

History of Homicidal Ideation: [ ] Yes [ ] No

Details: ____

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Eligible for SSI-Disability: [ ] Yes [ ] No

SSI Disability Application Submitted: [ ] No [ ] Yes (date):____________________________________

Eligible for Medicare/Medicaid: [ ] Yes [ ] No

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Referring Facility Name: ____

Referring Counselor Name: ____

Referring Counselor Phone: ___________________________________ Fax: _________________________

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NOTE: Provide client with necessary information to contact Community Service Board and a 30-day supply of ALL prescribed medications.

Distribution:

Original: Mental Health Record (section 7), along with original of Release of Information Form.

Only fax to the following if this form has not been completed in Scribe:

Fax Copy 1: Chief Probation Officer or Chief Parole Officer or both as applicable. Do NOT include supporting documents with this copy. Ensure the Release of Information Form is attached.

Fax Copy 2: Department of Community Supervision. Do NOT include supporting documents with this copy. Ensure the Release of Information Form is attached.

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***Note:* All sections *must* be completed. Write "unknown" or "N/A" where needed, but *do not* leave any section blank. Do NOT write, "see attached" for any answer; supporting documents are *not* sent to Probation, Parole or the Department of Community Supervision (DCS). Ensure the Release of Information Form is attached. Ensure Type of Release is the same as indicated on the Release Certificate.**

Re-Entry Referral Form
Offender Information Sheet

[ ] An appointment has been made for you with the following mental health provider:

Provider Name: ____

Appointment Date: __________ Time: ________ Phone #: ____________________

Address: ____

____

[ ] No appointment has been made. Please call Behavioral Health Link at 1-800-715-4225.

[ ] Probation/Parole Officer Name:______________________________________
(circle)

Phone #: ____________________

If you cannot keep this appointment or if you wish to decline services and are not required by Probation/Parole to accept services, please call the above number and inform the Community Service Board.
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Note: If you are on medication, please make sure a supply of your medication is given to you at the time you leave the prison/detention/transition center.
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