Federation of Organizations

Helping People to Help Themselves

Residential Transition Support (RTS) Referral Form

Client's Name:_____

Client's Address:_____

Contact Number: _____ **Date of Birth:**_____

Primary Psychiatric Diagnosis:_____

Co-occurring diagnosis (if applicable): _____

Current level of housing:_____

Current medication hold:_____

Referral Source:

Agency/Program : _____

Address/Phone: _____

Primary Case Worker:_____

Work: _____ Fax: _____ Cell:_____

- Please check here if the client is in agreement with meeting with RTS staff and learning about RTS services.

Reason for Referral:_____

_____

_____

_____

_____

Is the client residing in SPA housing? Yes/Agency_____ No/Reason _____

If not, is there a plan for them to be referred to SPA?_____

Please attach these documents:

- Psychosocial
- Psychiatric Evaluation
- Physical*Required if services will include health services or co-occurring medical disorders are present.

Please fax or email all referral forms and supporting documentation to: Attn: Eric Schatzel
Fax: 631.698.0137 or Email : ESchatzel@fedoforg.org

RTS use only

Referral Received Date: _____
Screening Date:_____

Admitted: _____ **HIGH RISK:** _____
Declined & Reason:_____
_____