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 Housing:

Is the client residing in SPA housing?

- o Yes Agency/Level_____
- o No Discuss current housing situation _____

_____

Current medication hold:_____

Referral Source:

Agency/Program : _____

Address/Phone: _____

Primary Case Worker:_____

Email: _____ Cell:_____ Fax: _____

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

Reason for Referral:_____

_____

_____

_____

Please attach these documents:

- o Psychosocial
- o Psychiatric Evaluation
- o 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: Jen Riley
Fax: 631.698.0137 or Email : Jriley@fedoforg.org

RTS use only

Referral Received Date: _____
Screening Date:_____

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