



**Mental Health Association in Passaic County  
Intensive Family Support Services Program (IFSS)  
Referral Form**

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**REFERRAL SOURCE**

**AGENCY/PHONE**

**DATE**

**Family Information:**

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**NAME**

**RELATIONSHIP TO CONSUMER**

**AGE**

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**NAME**

**RELATIONSHIP TO CONSUMER**

**AGE**

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**NAME**

**RELATIONSHIP TO CONSUMER**

**AGE**

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**NAME**

**RELATIONSHIP TO CONSUMER**

**AGE**

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**ADDRESSES**

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**PHONE NUMBERS**

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English     Spanish     Other

**PRIMARY LANGUAGES**

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**REASONS FOR REFERRAL**

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**PREVIOUS SUPPORT / EDUCATIONAL INVOLVEMENT**

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**OTHER SOURCES OF STRESS** (i.e. marital, illness, unemployment, etc.)



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**Consumer Information**

NAME

AGE

ADDRESS

PHONE

No  Yes

DOES CONSUMER HAVE CHILDREN UNDER 18 YEARS OF AGE?

IF YES, WHAT ARE THEIR NAMES AND AGES?

DSMIV DIAGNOSIS

MEDICATION

SERVICE INVOLVEMENT

DESCRIBE CONSUMER'S COMPLAINT WITH TREATMENT

LAST HOSPITALIZATION (LOCATION AND DATE)

FAMILY'S PERCEPTION OF CONSUMER'S MENTAL ILLNESS

FAMILY'S EXPECTATIONS OF SERVICES PROVIDED

Education about mental illness  Individual Support  Support Group  Respite  Connection to Services  Other (explain)

FAMILY NEEDS

ADDITIONAL COMMENTS

COMPLETED BY

DATE

**Please mail or fax to:**

Mental Health Association in Passaic County  
404 Clifton Avenue  
Clifton, NJ 07011  
Phone: (973) 478-4444  
Fax: (973) 478-0941