INTENSIVE FAMILY SUPPORT SERVICES PROGRAM (IFSS)
REFERRAL FORM

Date_____

Referral Source_____

Agency/Phone_____

Family Information

Name(s)	Relationship to consumer	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Addresses(s)_____

_____

_____

_____

Phone Number(s)_____

_____

Primary Language(s) English____ Spanish____ Other____

Reason(s) for Referral

_____

_____

_____

Previous support/ educational involvement _____

_____

Other sources of stress (i.e. marital, illness, unemployment, etc.)

_____

_____

Consumer Information

Name_____ Age_____

Address_____ Phone_____

_____

_____

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 compliance with treatment _____

_____

Last Hospitalization (Location and Date)_____

Family's perception of consumer's mental illness _____

_____

_____

Family's expectations of services provided_____

_____

_____

Family Needs (Please Check)

_____Education about mental illness _____Individual Support
_____Support Group _____Respite
_____Connection to Services _____Other (please explain)

Additional comments _____

_____

_____ _____

Completed By Date