RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

Sunshine Lady House Referral Form

Please fax completed referral to 540-374-3387. For questions please call 540-374-3386.

Referral Information

Referral Date: _____Referral Agency:_____

Referral Staff: _____Referral Phone:_____

Individual Information

Name: _____(preferred)_____

Date of Birth: _____Sex/Gender: _____ Phone Number: _____

Emergency Contact: Name: _____Number:_____

Insurance/Medicaid #: _____

Diagnosis:_____

Presenting Concerns

1. What concerns, symptoms, or events led to this referral?

_____

_____

_____

2. Current risk concerns:

☐ Suicidal ideation ☐ Homicidal ideation ☐ Self-injurious behavior

☐ Suicidal behavior ☐ Violent behavior ☐ None reported

Please explain:

_____

_____

Admission Criteria Screening

Individual currently:

☐ Willing to participate in treatment

☐ Able to perform ADL's independently

☐ Medically stable

☐ Able to follow directions/redirection

☐ Appropriate for an unlocked setting

☐ Not actively aggressive or assaultive

Medical History

1. Current medical conditions:

_____

_____

_____

_____

_____

2. Current medications (include dosage):

_____

_____

_____

_____

_____

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3. Allergies:_____

4. Primary Care Provider:_____

5. Any recent hospitalization or emergency room visits? ☐ Yes ☐ No

If yes, explain:_____

Substance Use History

1. Current or recent substance use? ☐ Yes ☐ No

Alcohol: Frequency_____Last Use_____Amount_____

Opioids: Frequency_____Last Use_____Amount_____

Stimulants: Frequency_____Last Use _____Amount_____

Cannabis: Frequency_____Last Use _____Amount_____

Benzodiazepines: Frequency_____Last Use_____Amount_____

Other: Frequency_____Last Use_____Amount_____

2. History of withdrawal symptoms? ☐ Yes ☐ No

3. History of withdrawal seizures or Delirium Tremens? ☐ Yes ☐ No

4. Current intoxication or withdrawal concerns? ☐ Yes ☐ No

If yes, explain:_____

Psychosocial Information

1. Current living situation/housing status:_____

2. Legal issues/probation/court involvement:_____

3. History of trauma or abuse? ☐ Yes ☐ No ☐ Declined to Answer

4. Cultural, spiritual:_____

5. Accessibility or language needs:_____

Referral Outcome

☐ Accepted Pending Review ☐ Declined Admission / Referred to Higher Level of Care
☐ Further Assessment Needed

Reason/Notes:

_____

_____

_____

SLH Staff Completing Review: _____

Signature: _____Date: _____