Infinite Solutions Behavioral Services, LLC

Demographics:

Name:	DOB: ____/______/____	Social Security No:
Address:	Phone No:	Alternate Phone No:

Where does the member currently reside: ☐ Private ☐ Alone ☐ With Family Members ☐ Shelter
☐ In a Facility __________________ If in a facility, what is the discharge date: _____________________________?

Insurance Information: **(Check all that apply):**

☐ Medicaid: ______________ ☐ Aetna: ____________
☐ Va. Premier: ____________ ☐ Anthem: ____________
☐ United HC: ________________ ☐ Optima: _____________

- Is the individual receiving case management services? ☐ Yes ☐ No **If yes: Explain**

- Prior Hospitalization: ☐ Yes ☐ No: If Yes, Where and What Time Period

Where:	Time Period:

- **Have you been prescribed a psychotropic medication in the past 12 months?** ☐ Yes ☐ No

Are you able to List them:

- Does individual have a diagnosis of mental illness? ☐ Yes ☐ No Please List:

- Does member have a Primary Care Physician (PCP) ☐ Yes ☐ No:

If so, Name:	Name of the Facility:

Reason for Referral:

☐ Aggressive Behavior
☐ Having difficulty in establishing or maintaining normal interpersonal relationships
☐ Homeless
☐ Crisis Services
☐ Emotional Problems
☐ Homicidal/Suicidal thoughts or attempts
☐ Inadequate nutrition
☐ Unable to manage finances
☐ Health or safety is jeopardized
☐ Repeated interventions by the mental health, social service, or judicial System
☐ Unable to recognize personal danger
☐ Unable to recognize significantly inappropriate social behavior
☐ Talks to him/herself
☐ Hears Voices
☐ Major Depression
☐ PTSD
☐ Schizophrenic Spectrum

Additional Comments:

☐ Bipolar I or II

Name of the Person Obtaining the Information:	Date: