



Safe Entry, Inc.
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Safe Entry, Inc. II
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Madison, TN 37115
(615) 997-3491

REFERRAL APPLICATION

This referral is being made for:

_____ Adult Day Care Treatment/Psychosocial Rehabilitation/MH Outpatient

_____ Supportive Housing

_____ Transitional/Independent Housing

_____ Enhanced Supportive Housing

Person making referral/agency: _____

Contact Number: _____

Anticipated enrollment date of consumer: _____

Insurance Provider: _____

Consumer Information:

Name: _____

Date: _____ DOB: _____ Sex: _____

Social Security Number: _____ Insurance ID Number: _____

Race: _____ Marital Status: _____ Address: _____

Zip Code: _____ Phone number: _____

Current Living Arrangements: _____

Monthly Income: _____ Source of income: _____

SNAP Case Number: _____

Current treatment facility/Case Manager and phone:

Has the consumer ever been a participant of Safe Entry, Inc.? If so, when:

Does the consumer have a history of substance abuse? If so, please describe any current or past use.

Please list **ALL** medications/doses/times taken

Prescribing Physician:

_____ Agency: _____

NUMERIC AND DIAGNOSTIC INFORMATION:

Axis 1: _____

Axis 2: _____

Axis 3: _____

Axis 4: _____

History of psychiatric inpatient admissions (date, reasons and precipitating factors):

Does consumer have a history of suicidal, violent, or aggressive behavior? Yes or No

If yes please explain: _____

What type of transportation will consumer use if attending the Mental Health Outpatient Program?

What is the consumer's work history? _____

What is the consumer's housing history? _____

Has the consumer had difficulty in maintaining housing? Yes or No. If yes, please explain:

ALL REFERRALS REQUIRE A PHYSICIAN SIGNATURE:

Physician Signature: _____ Date: _____