Håtsa Program
665 Marine Corps Dr. Ste.102 Tamuning, GU 96913
www.westcare.com | hatsa@westcare.com

OUTPATIENT REFERRAL

Client Information				
Last Name:		**First Name:**		**M.I.**
Social Security Number:	**Date of Birth:**	**Age:**	**Marital Status:**	**Sex:** □ **Male** □ **Female**
Ethnicity/Race:	**Interpreter Services Needed:** □ **Yes** □ **No**		**If yes, in what language:**	
Current Housing Situation:				
Residential Address:		**Village:**		**Zip Code:**
Mailing Address:		**Village:**		**Zip Code:**
Primary Phone:		**Secondary Phone:**		
Email Address:				

Emergency Contacts:		
Name:	**Contact:**	**Relationship:**
Name:	**Contact:**	**Relationship:**

Services Referred For:

□ Substance Use Assessment & Treatment □ Behavioral Health Treatment □ Co-Occurring Treatment

□ Other (Please Specify): _____

Referral Source Information:

Referring Source: □ Self-Referral □ Other (Please Specify): _____

Name of Referring Person:	**Contact Information:**

Name & Address of Agency being referred to:

Client Consent for Referral

I ,_____ authorize _____
(Print Client Name) **(Name of Referring Party)**

to share this referral form with the above Organization/ Agency. An additional release of information will be required to discuss involvement in services.

Client Signature_____ **Date:** _____

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PRE-ADMISSION SCREENING

ELIGIBILITY		
1.	Are you 18 years of age or older?	□ Yes □ No
2.	Do you lack a fixed, regular, and adequate nighttime residence?	□ Yes □ No
3.	Are you currently living in a shelter or place not meant for human habitation?	□ Yes □ No
4.	Are you fleeing or attempting to flee domestic violence?	□ Yes □ No
5.	Are you at imminent risk of losing your house within the next 2 weeks?	□ Yes □ No
6.	Where you homeless in the 60-day period before enrollment and has found housing since?	□ Yes □ No
7.	Do you consent to receive substance use and/or behavioral health treatment?	□ Yes □ No

MENTAL HEALTH NEEDS and OTHER INFORMATION		
8.	Are you currently thinking about committing suicide? ***If yes, stop screening and have Clinician complete Columbia Suicide Severity Rating Scale*** **(C-SSR).**	□ Yes □ No
9.	Are you currently thinking about harming other people? ***If yes, stop screening and have Clinician meet with individual.***	□ Yes □ No
10.	Do you have any previous mental health conditions?	□ Yes □ No
11.	Do you have any transportation needs?	□ Yes □ No

OTHER NOTABLE INFORMATION

_____

_____

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