SPOP

SERVICE PROGRAM FOR OLDER PEOPLE, INC.
302 WEST 91ST STREET, NEW YORK, NY 10024
188 WEST 88TH STREET, NEW YORK, NY 10024
PHONE: 212-787-7120 FAX: 917-441-7421

INITIAL REFERRAL

☐ Clinic
☐ PROS
☐ Dual Diagnosis

☐ Satellites / Site
Grand Street

☐ COPS

☐ Homebound
☐ Bilingual
☐ None of the above

CLIENT NAME _____ DATE OF REFERRAL

REFERRER ◯SELF ◯OTHER
Name Agency / Title / Relationship Telephone Number

MEDICARE ID MEDICAID ID

OTHER INSURANCE

SOCIAL SECURITY # : MARITAL STATUS: Married

ADDRESS TELEPHONE

DOB AGE EMERGENCY CONTACT
Name Relationship Telephone Number

EMERGENCY CONTACT 2

LIVES: ◯ALONE ◯WITH _____
Name Relationship Telephone Number

WHO CAN HELP ENGAGE IN TREATMENT? _____
Name Relationship Telephone Number

HOME SAFETY Are there firearms in the home? ◯YES ◯NO Are there other weapons in the home? ◯YES ◯NO

CALL FIRST: ◯ CLIENT ◯ REFERRER ◯OTHER _____

OTHER MENTAL HEALTH PROVIDERS INVOLVED? ◯NO ◯YES – names and contact information is **required**
Who is expected to prescribe psychotropic medications? ◯SPOP ◯Outside Psychiatrist ◯Primary Care MD

	Name	Specialty / Clinic	Address / Telephone #
Presciber:	_____	_____	_____
Other:	_____	_____	_____

PHYSICIAN / HOSPITAL / CLINIC

Name	Specialty / Clinic	Address / Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOMECARE ◯YES ◯NO

Agency _____ Phone # _____ Contact Person _____

Name of Home Attendant _____ Days _____ Hours _____

OTHER ORGANIZATIONS INVOLVED

Name	Address	Telephone Number(s)
_____	_____	_____
_____	_____	_____

INITIAL REFERRAL **Client:**

CLIENT REASON FOR REFERRAL (Include history of problem, symptoms, and current situation):

PSYCHIATRIC HISTORY (e.g. prior treatment, hospitalizations, suicide, violence, substance abuse):

MEDICAL PROBLEMS (e.g. current medical status, recent hospitalizations and surgery):

MEDICATIONS:

Medication	Dosage	Medication	Dosage

SOCIAL NETWORK (e.g. family, friends, community involvement, religious affiliations, activities)**:**

INTAKE COMPLETED BY: SIGNATURE _____

PRINT NAME:_____