HealthCare Partners, IPA
HealthCare Partners, MSO

Referral for Social Work Services

Member Name: _____ Member ID#: _____

Member e-mail address (if known): _____

Language(s) spoken: _____

Member Cognition: _____

Cultural preference if any that could influence intervention: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____

Relationship: _____

PRIMARY REASON(S) FOR REFERRAL (select all that are being requested)

____ Support to manage mental health illness(es)

____ Active substance abuse

____ Linkage to behavioral health providers

____ Community resources (i.e. transportation)

____ Food insecurities

____ Medicaid/Long term care planning

____ Housing concerns

____ Concerns for abuse (i.e. child/elder abuse)

____ Gather psychosocial information

____ Other (specify):

Please provide any additional details below:

BEHAVIORAL or SUD DIAGNOSIS:

PHQ2: Yes (____) If Yes, Score: (____) No (____)

PHQ9: Yes (____) If Yes, Score: (____) No (____)

Would you like to be notified of the outcome of the referral? Yes ____ No ____

Send completed referral form via fax (516) 394-5665 or email: SWRef@hcpipa.com