

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 REFFERAL (check 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 NO

Score:

PHQ9: YES NO

Score:

Would you like to be notified of the outcome of the referral? YES NO

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