

MAPLE SHADE PSYCHIATRIC REHABILITATION PROGRAM
RESPITE CARE PROGRAM

CLIENT: _____ DOB: _____ SEX: _____

SS#: _____ RACE: _____ MA # _____

ADDRESS: _____

TELEPHONE: _____ CELL: _____

PRIMARY CARETAKER: _____

REFERRED BY: _____

REASON FOR REFERRAL: _____

IS CLIENT A WAIVER CLIENT YES _____ NO _____

DIAGNOSIS:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: current _____ past _____

MEDICATIONS:

PARTICIPATING IN OUT PATIENT MENTAL HEALTH SERVICES: YES__ NO __

SCREENING SCHEDULED DATE:

STAFF RECEIVING REFERRAL:

DATE:

*****Please attach the following documentation:**

- 1. Psychiatric Evaluation dated within past 6 months**
- 2. Immunization records**
- 3. Current yearly physical**