S.T.A.R. Referral Form

Date of Referral: _____ **Referred by:** Clinic ☐ Doctor ☐ Self ☐
Behavioral Health Provider ☐ Family/Friend ☐ Other ☐

Member Information

Applicant Name: _____ Date of Birth: _____ AHCCCS ID#: _____

Diagnosis Code: _____ Physical Address: _____

Phone #: _____ Medication compliant for 7+ days or more? *Please circle Y / N*

Is the potential member involved in other systems of service? Check all that apply. DDD ☐ Probation ☐ Parole ☐

Other ☐ (If any boxes were checked, please explain) _____

Is the potential member currently employed or going to school? *Please circle Y / N*

Is the potential member willing to commit to attending STAR's day program at least twice a week? *Please circle Y / N*

Has the potential member been taking medication(s) as prescribed for the last 7 days or more? *Please circle Y / N*

Does the potential member have any behaviors or needs that require additional attention from S.T.A.R. staff: *Y / N*

Please explain: _____

Guardian Information (if applicable)

Guardian's Name: _____ Relationship to Potential Member: _____

Guardian's Phone # (if different from above): _____ Best time to contact: _____

Assigned Clinic Information

Assigned Clinic Agency: _____ Psychiatrist Name: _____

Case Manager Name: _____ Clinic Phone #: _____

CM Cell Phone #: _____ CM Email Address: _____

BELOW TO BE FILLED OUT BY S.T.A.R. STAFF

Areas of interest to potential member (check all that apply):

☐ Peer Support	☐ Recovery Focused Groups	☐ Discharge Care Coordination
☐ Individual Counseling	☐ Group Counseling	☐ Opioid Support Groups
☐ Independent Living Skills	☐ Job Skills/Employment Support	☐ Young Adult Program (Ages 18-25)
☐ Transportation	☐ Health, Wellness, and Exercise	☐ NTXIX Chronic Medical Services
☐ Housing	☐ Community Resources	☐ Nutrition/Cooking Classes

Location(s) of interest:

☐ S.T.A.R. Central (Phoenix)	☐ S.T.A.R. East (Mesa)	☐ S.T.A.R. West (Avondale)

Today's Date _____ **New Member Orientation scheduled for:** _____

Nursing Assessment scheduled for (within 30 days): _____

Revised 20191024

S.T.A.R. Referral Form (cont'd)

MEDICAL INFORMATION

Applicant Name: _____

DOB: _____ Age:_____ M _____ F _____

Phone: _____ PNO/Clinic: _____

Case Manager: _____ Clinic Phone: _____

CM Cell Phone: _____ Medical Insurance: _____

Psychiatric Dx/Diagnoses: _____

Does the potential member carry a current list of all medication with dosage? *Please circle Y / N*

Please list the potential member's current prescribed medication(s) and dosage: _____

_____

Please list any chronic physical health issues for which s/he is being seen: _____

_____

PCP's Name: _____ PCP's Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____ Address: _____

Does the potential member have an advanced directive? *Y / N* Additional Information: _____

_____

Please circle yes or no and provide additional information where applicable.

HX of Strokes?	y	n	
Prescribed Coumadin/other blood thinners?	y	n	
HX of Cardiac disease?	y	n	
Prescribed Nitroglycerine?	y	n	
Does s/he have a bleeding disorder?	y	n	
Hearing impairment?	y	n	
HX of seizures or epilepsy?	y	n	
Emphysema/COPD?	y	n	
Asthma?	y	n	
Diabetes?	y	n	
If yes, are you insulin dependent?	y	n	
High OR Low blood pressure?	y	n	
Does s/he have a communicable disease?	y	n	
STD or STI?	y	n	
Any recent operations or hospitalizations within 90 days?	y	n	Explain w/ date:_____ _____
Does s/he have a service animal or emotional support animal (ESA)?	y	n	Please specify:_____ _____
Any allergies?	y	n	Explain:_____ _____

STAR Staff Name, Credentials, & Signature _____

Applicant Signature_____ **Date** _____

Revised 20191024