



ANTHONY HOUSE

REFERRAL FORM

Name: _____ SS #: _____

Current or Last Address: _____

City, State, Zip Code: _____

Telephone Number where I can be reached: _____

Date of Birth: _____ Number of Family Members: _____

I. GENERAL

Can you take your own medication? YES NO

Can you manage your medical treatments on your own? YES NO

Can you dress and bathe yourself? YES NO

Can you clean your own clothes? YES NO

Can you keep your room clean and make your own bed? YES NO

Can you manage your own money? YES NO

Do you have friends or family nearby? YES NO

Can you work full time? YES NO

Have you been homicidal or had homicidal thoughts in the last 6 months? YES NO

Have you been suicidal or had suicidal thoughts in the last 6 months? YES NO

Do you have a legal guardian or payee? YES NO

Do you currently receive any of the following kinds of financial support? YES NO

-Service Connected Disability (____%, \$_____/Month) YES NO

-Non-Service Connected Disability (\$_____/Month) YES NO

-Non-VA Disability (e.g., SSDI)(\$_____/Month) YES NO

-Other Public Support (Food Stamps, Welfare, AFDC) YES NO

Are you enrolled in Vocational Rehabilitation (VA or State of Florida)? YES NO

Have you ever been in a transitional homeless shelter before? YES NO

Where? _____

When? _____

How much money have you received in the past 30 days? (Include all sources of income)

- { } No Income { } \$50-\$99 { } \$500-\$999
- { } \$1-\$49 { } \$100-\$499 { } \$1000 or more

Name: _____

Date: _____

II. LIVING SITUATION

What is your current residence? (Check only one)

Live in own apartment or room

Live with family or friends)

Shelter/Halfway House

No residence (on street or in woods)

Treatment Facility (Discharge Date: _____)

Length of stay at current residence? _____

Prior to that, where were you living? _____

III. LEGAL

Do you have any current outstanding or pending legal charges/warrants/issues? YES NO

If YES, what are they? And what county? _____

Please document any **past history**. If yes, provide explanation or further information in space provided below.

Military:

Court Martial YES NO

Other Disciplinary Actions (Article 15s) YES NO

Civilian:

Misdemeanors YES NO

Felonies YES NO

Driving (Traffic Violations or DUI) YES NO

Are you currently on probation or parole? YES NO

Have you been convicted of:

Murder YES NO

Armed Robbery YES NO

Destruction of Property YES NO

Domestic Violence YES NO

Name: _____

Date: _____

Have you been convicted of continued:

Child Abuse	YES	NO
Bomb Threats	YES	NO
Prostitution	YES	NO
Sexual Battery/Rape	YES	NO

Explain: _____

Do you have any debts to any individuals, Child Support, Court or have any outstanding court ordered fines or restitution? YES NO

IV. SUBSTANCE ABUSE

Do you think you have a current problem with alcohol or drugs? YES NO

Have you ever had a problem with alcohol or drugs? YES NO

During the past 30 days, how many days have you used or sold Alcohol/drugs? _____

Have you ever participated in substance abuse treatment? YES NO

Where? _____ When? _____

V. PSYCHIATRIC STATUS

Do you think that you have any current psychiatric or emotional problems? YES NO

Have you ever been hospitalized for a psychiatric problem? YES NO

In the past year, have you received any psychiatric care? YES NO

Where? _____ When? _____

Within the past 30 days, have you or do you now have:

Experienced serious depression	YES	NO
Experienced serious anxiety or tensions	YES	NO
Experienced hallucinations	YES	NO
Had trouble understanding, concentrating or remembering	YES	NO
Had trouble controlling temper or violent behavior	YES	NO
Had serious thoughts about suicide	YES	NO
Attempted suicide	YES	NO

Name: _____

Date: _____

Within the past 30 days, have you or do you now have continued:

Took prescribed medications for an emotional problem YES NO

Are you currently taking any medications for behavioral issues? YES NO

List those you take: _____

VI. MEDICAL

How would you describe your current health? { }Excellent { }Good { }Fair { }Poor

Have you ever been diagnosed with:

AIDS/HIV YES NO

COPD/Emphysema YES NO

Diabetes YES NO

Eye Problems (other than glasses) YES NO

Gastrointestinal Problems YES NO

Heart/Cardiovascular Problems YES NO

Hepatitis A/B/C YES NO

Hypertension YES NO

Liver Disease YES NO

Oral/Dental Problems YES NO

Orthopedic Problems YES NO

PTSD/Significant Trauma YES NO

Seizure Disorder YES NO

Significant Skin Problems YES NO

Seizure Disorder YES NO

Significant Skin Problems YES NO

Tuberculosis (TB) YES NO

Vascular Problems YES NO

Name: _____

Date: _____

Are you physically limited in your ability to do any of the following:

- Standing and Walking YES NO
- Stooping, Kneeling, Squatting YES NO
- Climbing and Balance YES NO
- Lifting and Carrying YES NO
- Bending YES NO
- Use of Hands YES NO
- Use of Feet YES NO

Other: _____

VII. CURRENT MEDICATION

Do you have a primary care physician? YES NO

When did you last receive medical care? When? _____ Where? _____

Are you taking any medications, vitamins or herbs not prescribed by medical staff? YES NO

Do you have medications that have been prescribed, but you do not take? YES NO

Please list all of the medications, vitamins or herbs you currently take: _____

Please list all of the medications you have been prescribed, but do not take: _____

VIII. EMPLOYMENT STATUS

What has been your usual employment pattern during the past year?

- Full Time (40hrs/wk) Part Time/Temp (Irregular) Retired/Disability
- Full Time (Irregular) Student Day Labor
- Part Time (Regular) Active Military Unemployed

How many days have you worked for pay in the past 30 days? _____

In the past 30 days, how much income came from work? _____

Name: _____

Date: _____

VIII: Employment Status Continued

What and when was your last permanent job? _____

What kind of work skills do you have? _____

What machines can you operate? _____

What is your principal occupational training? _____

What kind/type of job(s) do you feel most suited for? _____

What do you see yourself doing one year from now? _____

What kind of training do you feel you need to meet this goal? _____

Are there any circumstances that would limit your ability to work or limit the type of work you can do? _____

How many times have you quite a job in the past five years? _____

What types of jobs have you quit? _____

How many times have you been fired in the past five years? _____

What types of jobs have you been fired from? _____

Name: _____

Date: _____

VIII. Employment Status Continued

Please check all of the reasons that have caused you to leave a job in the last year?

- Transportation
- Pay was too low
- Substance Abuse
- Did not like work hours
- Health problems
- Child care problems
- Did not like job duties
- Did not like supervisor
- Did not like co-workers

Please check all of the problems you have had while working in the last five years:

- Missing Work
- Leaving work without permission
- Arriving late or leaving early
- Getting along with co-workers
- Getting along with supervisors
- Usually get the "short end of the stick"
- Got made and quit
- Get frustrated with too many rules
- People watching me all the time
- People talking about me
- Personal problems
- Emotional problems
- Too many pressures
- Transportation problems
- Lack of self-confidence
- Lack of skills
- Unable to concentrate
- Dissatisfied with what I was doing
- Disliked work conditions or pay
- I knew more than my supervisors
- Not able to work fast enough
- Poor quality work

What is your education level?

- Some High School
- Some College
- Bachelors Degree
- Vo-Tech Training
- HS Diploma/GED
- Associate Degree
- Graduate Degree
- Vo-Tech Certificate

Areas I have received education or training: _____

IX. YOUR GOALS

What do you hope to accomplish if admitted to the Anthony House? _____

What are your short-term goals? _____

Name: _____

Date: _____

IX. Your Goals Continued

What are your goals and/or plans for employment? _____

What are your goals and/or plans for permanent housing? _____

To the best of my knowledge, the information I have provided is correct.

Signature

Date