Southern Tier Mobile Integration Team Referral Form

**\*Please include a completed release of information if available\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Person being referred:** |  | **Person making referral:** |  |
| **Parent/Guardian name(s):** |  | **Phone:** |  |
| **Phone:** |  | **Cell Phone:** |  |
| **Cell Phone:** |  | **E-mail:** |  |
| **Address:** |  | **Agency & Address:** |  |
| **County of Residence:** |  | **Case/Care Manager:** |  |
| **Age / Sex:** |  | **Contact Information:** |  |
| **Date of Birth:** |  | **Mental Health Diagnosis:** |  |
| **Race:** |  | **High Risk Behavior(s):** |  |
| **Preferred Language:** |  | **Aggression:** |  |
| **Last Grade Completed:** |  | **Alcohol / Drug use:** |  |
|  |  | **Self-Injury behavior:** |  |
| **Emergency Contact:** |  | **Date of most recent ED/CPEP Visit or Hospitalization:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **MIT Services being requested** | **Check**  **Box** | **MIT Services being requested** | **Check**  **Box** |
| **Transitional Support for Inpatient to Community** |  | **Medication Coordination/Education/Assistance** |  |
| **Socialization/Recreation** |  | **Housing Support/Linkages** |  |
| **Skill Building /Prevention of Hospitalization** |  | **Transportation Planning/Support/Linkage** |  |
| **Activities of Daily Living Support/Training** |  | **Other-Describe below** |  |

**Please provide a brief summary and rationale for services requested:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your current supports:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax or e-mail this referral to:**

**FAX: 607-763-2792**

[Softiya.Umar@omh.ny.gov](mailto:Softiya.Umar@omh.ny.gov) or call 607-763-2761

(Broome/Chenango/Delaware/Otsego/Tioga/Tompkins)

[Colette.Marcellus@omh.ny.gov](mailto:Colette.Marcellus@omh.ny.gov) or call 607-737-4944

(Cattaraugus, Allegany, Steuben, Schuyler, Chemung, Tioga, Tompkins)

[Rebecca.Thomas@omh.ny.gov](mailto:Rebecca.Thomas@omh.ny.gov) or call 315-350-0289

(Wayne, Ontario, Seneca, Yates)