Outreach Navigation Referral Form

Email: connieM@ihshawaii.org
Fax: 808-845-9828

Date of referral:_____ Time of Referral:_____
Organization:_____
Person making referral: : _____
Phone: _____ Fax: _____
Email: _____ Name of Individual being Referred:_____
Description of the Subject: _____
_____
_____

Is the subject currently linked to any case manager, social worker or other support? Who?

Length of Time Homeless: _____
System high user? ☐ ER ☐ EMS ☐ Arrest ☐ Enforcements
Location_____
When is subject likely to be found there? _____
DOB of Individual if known _____
☐ Male ☐ Female ☐ Transgender

Any known relatives: _____Contact info for relatives_____
Veteran Status:_____ Legal Status: _____

Has this individual ever been diagnosed with a mental illness/substance use disorder in the past? When?

Was he/she ever treated for this mental illness or substance use disorder? When and where?

Has this person ever been the subject of an emergency Mental Health evaluation (MH1) and taken to the emergency room for such? Y. N.
Date(s)

What evidence is there that this individual has lost the ability to be self-preserving or able to improve their health?

The individual is able to
☐ access food independently
☐ toilet themselves appropriately
☐ avoid being victimized.
☐ avoid behavior that endangers himself/herself
☐ manage finances competently to meet needs

For Office Use Only: Referral Accepted for: Referral redirected to: _____
Assertive outreach ☐
Guardianship ☐
ACT ☐