REGION II HUMAN SERVICES **ADULT SUPPORT SERVICES**

Email completed referral form & release of information to: referral@r2hs.com

☐ Community Support or ☐ Emergency Community Support &/or ☐ Day Support

Date: _____ *ASP.Referral.Form.6.23.2026*

Referring Person/Agency: _____**Phone:** _____
Email: _____ **Relationship to Person Referred:** _____

Person Being Referred:
Full Name: _____**Date of Birth:** _____ **Social Security #:**_____
Phone: _____ **Address:** _____ **City**:_____ **Zip Code**:_____
Preferred Language: _____ **Insurance (if known):** _____
Guardian: ☐ Yes ☐ No **If Yes, Name & #:**_____

Reason for Referral:
_____
_____

Known mental health diagnosis? ☐ Yes ☐ No If yes, list:_____

Signs of moderate–to–severe mental health needs (check any): ☐ Symptoms make daily life difficult ☐ Trouble staying stable without support ☐ Frequent emotional or behavioral crises ☐ Past psychiatric hospitalization ☐ Difficulty following treatment without help
Does the person appear to have a moderate–to–severe mental health condition? ☐ Yes ☐ No ☐ Unsure

Current alcohol or drug use? ☐ Yes ☐ No If yes, list: _____

Signs of moderate–to–severe substance use disorder (check any): ☐ Daily or heavy use ☐ Withdrawal symptoms ☐ Prior detox or treatment ☐ Loss of control over use ☐ Continued use despite major problems ☐ Cravings or strong urges ☐ Legal, financial, or housing problems related to use

Does the person appear to have a moderate–to–severe substance use disorder? ☐ Yes ☐ No ☐ Unsure

Functional Limitations: *Check all that apply and related to mental health or substance use disorder*

Daily Living: ☐ Difficulty with personal care ☐ Difficulty managing medications ☐ Unsafe or unstable living space

Community Living: ☐ Housing instability ☐ Trouble with transportation ☐ Difficulty navigating healthcare/benefits

Social/Interpersonal: ☐ Limited support system ☐ Difficulty maintaining relationships ☐ Difficulty communicating needs

Cognitive/Behavioral: ☐ Trouble planning or completing tasks ☐ Difficulty managing emotions/behavior ☐ Impaired judgment

Employment/Education: ☐ Difficulty keeping a job ☐ Difficulty attending school/training

Brief description of how these affect daily life:
_____
_____

Children ages 0–18 living in the home or plan for re-unification? ☐ Yes ☐ No

In the past 15 days, has the person experienced (check any): ☐ Severe emotional distress ☐ Thoughts of harming self ☐ Thoughts of harming others ☐ Crisis call, ER visit, or hospitalization ☐ None of the above

Receiving behavioral health services now? ☐ Yes ☐ No If yes, list: _____