SULZBACHER
HOUSING. HEALTHCARE. HOPE.

Date of Referral : _____

SOAR CASE MANAGEMENT REFERRAL FORM

1. **Name of Patient being Referred: _____**

2. **Psychiatric Diagnosis: _____**

3. **Medical Diagnosis: _____ _____**

4. **Housing Status: _____**

5. **Does the Patient have a pending SSDI/SSI claim? _____**

6. **Does the patient have recent substance use history? _____**

7. **Does the patient have a history of Baker Acts or psychiatric hospitalizations? __ _____**

8. **Why is the patient unable to work? _____**

Referral Source & Rationale for referral : _____

Contact Information: _____

Patient Contact Info: _____