New Horizons Re-Entry Program
Referral Form

Name: _____ **Birth Date:** _____

Address upon release: _____

Contact #: _____

Contact Person (not required if client's phone): _____

Incarceration Date: _____

Release Date: _____

Diagnosis List – *Must have one or more of following. (Referrals will not be accepted without at least one qualifying diagnosis)*

Schizophrenia: □295.1 □295.2 □295.3 □295.4 □295.6 □295.9

Bipolar Disorder: □296.0 □296.1 □296.4 □296.5 □296.6 □296.7 □296.8

Major Depressive Disorder: □296.20 □296.23 □296.24 □296.30 □296.33 □296.34

Other Psychotic Disorder: □297.1 □298.9

Schizotypal and Borderline Personality Disorders: □301.22 □301.83

Referring agency: _____

Contact Person: _____

Contact Number: _____

What were the client's charges that led to incarceration?

_____

_____

_____

_____

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Will client be released on any of the following?-if any are checked please list the contact information

□ Conditional Release □ Probation □ Parole

Contact Name:_____ Phone Number:_____

What Services has the client been receiving while incarcerated?

□ Medication □ Counseling □ Substance Abuse Treatment

□ GED/Educational services □ Other: _____

Will the client be on medications when released? □ yes □ no

If yes,

Will the client be released with: □ medication(s) □ prescription(s)

How many days of medication will be given at release?

□ 5 days □ 10 days □ 20 days □ 30 days □ 60 days □ 90 days

□ Other: _____

What medications will the client be released on?__

Medication Name	**Dosage Information**

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Community Services- Please check all of the services a client will need upon release

□Mental Health Provider □Somatic Provider □Substance Abuse Treatment

□ Psychiatric Rehabilitation Program □ Mental Health Case Management

□Apply for a medical card □Food Stamps □Photo ID □Birth Certificate □Housing

□ Pharmacy assistance □Employment Assistance □Apply for Social Security Benefits

□Reactivate Social Security Benefits □Other:_____

Scheduled aftercare appointments (if available):

Type of Service	**Provider Name**	**Contact #**	**Appointment Date**	**Time**
Mental Health				
Somatic Care				
Substance Abuse				
Psychiatric Rehabilitation Program or Case Management Services				

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Type of Service	**Provider Name**	**Contact #**	**Appointment Date**	**Time**
Other: Please Specify				

Additional Information: _____

_____

_____

_____

Please fax completed form to Sarah Pinardi at 301-777-5621

New Horizons Re-Entry Only

Eligible for New Horizons Re-Entry Services ☐Yes ☐No

Reason if Denied: _____

_____

_____

If Yes, Next Steps: _____

_____

_____

_____