Gateway Support Services, Inc.

940 Gillingham Court
Kissimmee, FL, 34758

www.gatewayss.org
support@gatewayss.org

(813) 857.5084
(855) 631.0056

IL-REFERRAL FORM

Referral Source

- ☐ Camelot Community Care/Eckerd
- ☐ Family First Network
- ☐ Big Bend Community Based Network
- ☐ Partnership For Strong Families
- ☐ Family Support Services For North Florida
- ☐ Kids First Of Florida
- ☐ My Family Integrity Program
- ☐ Childrens Network Of Southwest Florida
- ☐ Brevard Family Partnership
- ☐ Community Partnership For Children
- ☐ Kids Central Incorporated
- ☐ Heartland For Children
- ☐ Communities Connected For Children
- ☐ Safe Children's Coalition
- ☐ Eckerd Connects
- ☐ Embrace Families
- ☐ Child Net Inc.
- ☐ Citrus Family Care Network
- ☐

Cost per bed: ☐ Single $2,000 Per Month ☐ Mother & Child $2,300 Per Month

Referred By (Name and Contact# of person completing the form)	Phone

Demographic Information

Young Adults Name	D.O.B	Age	Last four digits of SS#

Gender	Marital Status	Race	Phone#
☐ Male ☐ Female			

Current Address	City	State	Zip

# of children living with parent	(1) Age of Child	(2) Age of Child	Currently Pregnant	How Many Weeks
			☐ Yes ☐ No	

School Information (If Applicable)

Name of Current School	Grade Level	Ph#	Fax#

Address	City	State	Zip

School Counselor/Academic Advisor

Other Information

Employment Status (if applicable)

Place of Employment	
	☐ F/T ☐ P/T

Current Address	City	State	Zip

Hours Per Week	Hire Date	Phone#	How does young adult commute to work

Medical & Mental Health Information

Is The Client Currently Receiving Mental Health Services?	☐ Yes ☐ No	Therapist Name	Facility	Contact#

Are You Planning On Discontinuing Services With These Providers?	☐ Yes ☐ No	If yes, reason

Has Client Been Hospitalized For Psychiatric Treatment In The Past?	☐ Yes ☐ No	If yes, Please Indicate Most Recent Admission

Is The Client On Any Psychiatric Medication?	☐ Yes ☐ No	Are Medications Prescribed By Psychiatrist ☐ Yes ☐ No	If yes, PLEASE COMPLETE "MY MEDICATION LIST"

Initial

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Primary Care Doctor

Primary Care Doctor Name	Facility	Phone#

Any Medical Problems? ☐ Yes ☐ No | **List Medical Issues**

History Of Substance Abuse

Any History Of Substance Abuse? ☐ Yes ☐ No | **If Yes, Is Substance Use Active** ☐ Yes ☐ No | **List substance use**

Are you seeking treatment for substance abuse? ☐ Yes ☐ No | **OR** | **In Remission** ☐ Yes ☐ No

Physical Health

Any History of Traumatic Brain Injury? ☐ Yes ☐ No | **Any History Of Being Diagnosed With A Developmental Disorder?** ☐ Yes ☐ No | **If Yes, Please Indicate If Client Can Communicate Verbally** ☐ Yes ☐ No

Please mark any of the following if individual needs assistance with any of the following
☐ Eating ☐ Bathing ☐ Ambulating ☐ Transferring ☐ Dressing ☐ Incontinent of Bowl ☐ Bladder

Is There a Legal Guardian or Power of Attorney? ☐ Yes ☐ No | **Name of Legal Guardian/Power of Attorney**

Phone	Email

Current Address	City	State	Zip

Legal History

Any Active Legal Concerns? ☐ Yes ☐ No | **Please Decribe**

____

____

Are you on probation ☐ Yes ☐ No | **Name of your probation officer** | **Phone**

Housing

Requested date to tour IL-center	Requested move in date

Please fax or email this form
Attention IL-Extended Foster Care Fax: 855.631.0056 Email: support@gatewayss.org

Insurance

Please list current insurance provider if the young adult needs assistance with none-skilled care within transitional center:

☐ Private Pay: Please check here if young adult will pay via private pay

Current Insurance Provider	Medicaid Number	Insurance Case Manager Name

Email:

Please describe in detail the physical need(s) and or mental health triggers of the young adult

Please list all mental health diagnoses. If Possible please list DSM code *(Please send proof of diagnosis)*

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

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M Y MEDICATION LIST

Young Adults Name	Last 4 SSN
Pharmacy Name	Phone

Does this individual require medication reminders? ☐ Yes ☐ No

LIST ALL PRESCRIPTIONS, OVER- THE- COUNTER MEDICATION, VITAMINS, HERBS, DIETARY SUPPLEMENTS, OXYGEN, INHALERS AND HOMEOPATHS REMEDIES.

Medication	Dose	When Taken: Daily, Bedtime	Reason for taking medication	Prescribing Doctor	Doctor Phone

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Pharmacy Name	**Phone**
Does this individual require medication reminders? ☐ Yes ☐ No	

LIST ALL PRESCRIPTIONS, OVER- THE- COUNTER MEDICATION, VITAMINS, HERBS, DIETARY SUPPLEMENTS, OXYGEN, INHALERS AND HOMEOPATHS REMEDIES.

LIST ALL ALLERGIES AND REACTION	
ALLERGIES	REACTION

☐ **Please check this box if allergies are unknown or to the best of your knowledge the young adult has no allergies**

Signature

Date