RHJMHC Referral Form

Please complete this form with any information you have about the referred individual. Fields may be left incomplete if unknown. Once you have completed, save the form and email directly to kroyston@rockinghamcountyva.gov

Date and Time		
Referral Date:	**Day of Week:** ○M ○Tu ○W ○Th ○F ○Sa ○Su	**Time:** _____ □ am □ pm
Referral Information		
Referral Type	□ **RHRJ Facility** □ **CSB Wellness Check** □ **Court Services Request** □ **Law Enforcement Request** □ **Dispatch 911** ***CFS #:*** _____ □ ***Other:***	
Reason for Referral		
Previous CRT Contact	□ Yes □ No □ Unknown ***If yes, last known CRT contact****:*	
Consumer Information		
Name: (Last)_____ (First)_____		**Date of Birth:** ____/____/____
Race: □ White □ Black □ Asian □ Other:		**Ethnicity:** □ Hispanic □ Non-Hispanic
Age:	**Gender:** □ Male □ Female	**ESL:** □ Yes □ No ***If yes, primary language:***
Active Military: □ Yes □ No □ Unknown		**Veteran:** □ Yes □ No □ Unknown
Address:		
Phone #:	**Residency:** □ Harrisonburg City □ Rockingham County □ Other Town:	
Client History (Please complete as much as possible)		
Known Mental Health Diagnosis	□ **Yes** □ **No** ***If yes, explain:***	
Known Safety Risk	□ **Yes** □ **No** ***If yes, explain:***	
Additional Information		
Suggested Priority Level	*Note:* 1 indicates lower level of priority (suggested response within a week); 2 represents higher priority level (suggested response within 24 hours). □ 0 □ 1 □ 2	
Suggested Action	*Note:* Please be as specific as possible. Comments may include wellness check, transportation services, screening, assessment, secondary referral, or other actions.	
Assigned CRT ID No:		