

Apalachee Center, Inc.
2634-C Capital Circle, N.E. Tallahassee, Florida 32308
(850) 523-3468 / Fax (850) 523-3469

FACT REFERRAL FORM

Date Completed: ___/___/___

Referred Consumer Name: _____ ACHS#: _____

Current Residence / Contact information: _____

Family Contact: _____

Social Security #: _____ Age: _____ DOB: ___/___/___

Sex: Male Female Race: White Black Other: _____

Approx Discharge Date: ___/___/___ Nationality: _____ Fluent Language: _____

Benefits / Insurance: _____

Medicaid / Medicare #: _____

Referred by: _____ Phone #: _____

Reason for Referral: _____

Current Agency Involvement: _____

Most Recent Hospitalization: _____

Psychiatric Facility Names & Admission Dates: _____

Attached Admission / Discharge summary's: _____

Current Meds and Dosages: _____
(Psych and Medical Meds): _____

Current Psychiatric Status: _____

***Attach copies of most recent psychiatric evaluations, psychosocial reports, and physical/ neurological examination reports. Also include copies of recent discharge summaries and any psychological testing/ evaluations. In addition include lab results from the last year, any x-ray, EEG and MRI reports, TB testing records and immunizations.**

