St. Lawrence Psychiatric Center **Mobile Integration Team Referral** **Form MR 145** **Issued: 03/2015**	Patient Name (Last, First, M.I) Case No. DOB: SEX:

MOBILE INTEGRATION TEAM REFERRAL FORM

Facility name:		Date:	
Unit/Ward/Residence:			
Client's Phone number:			
Client's Address:			
Client's Social Security #:			
Referral Source and contact info:			
Therapist:		Psychiatrist/Provider:	
If a minor, guardian information (phone and address):			
Does individual agree to MIT involvement:	Yes No	**Attach SLPC Release of Information	
Ongoing management:	Yes No	Brief Management:	Yes No
School Information:			
Substance abuse information:			

Reason for referral (include significant clinical information i.e: **Safety issues, risk for violence, access to firearms, pets,** etc. that the MIT staff should be aware of):

Specific Goals:

Signature of Client: