APALACHEE CENTER, INC

NAVIGATE REFERRAL FORM

Date: _____

Name of person being referred: _____ Client # (if applicable): _____

Address: _____

Phone(s) #: _____ SSN: _____ DOB: _____

Current Living Arrangements: ☐ Independent ☐ Independent w/family
☐ Other (i.e. shelter, ALF): _____

Current Outpatient Mental Health Provider/Phone (if applicable): _____

Legal Guardian Name/Phone (if applicable): _____

Main Language(s): ☐ English ☐ Spanish ☐ French/Creole ☐ Other: _____
Funding Sources: ☐ SSI ☐ SSDI ☐ Employment ☐ None ☐ Other: _____
Insurance: ☐ Medicaid # _____ ☐ Medicare # _____
☐ Other: _____ ☐ None

Admission Criteria/Diagnosis information:

A. For this referral to be considered, the individual must meet ALL of the following criteria:

☐ Between the ages of 18-40

☐ New diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform disorder within past year

☐ Have received antipsychotic medications for less than one year

B. Exclusionary criteria:

- Significant intellectual disability or autism spectrum disorder
- Diagnoses of psychosis based on affective disorders (i.e. Anxiety Disorder or Bipolar Disorder/Bipolar Disorder with psychotic feature) or any of personality disorders

Diagnosis:	**Current Medication(s):**
Primary: _____	_____
Secondary: _____	_____
Tertiary: _____	_____
	_____

Reason for NAVIGATE Referral: (Please explain specific behaviors/symptoms exhibited, relationship with the family/support system, psychiatric inpatient history)**:**

_____

_____

_____

_____

_____

_____

Client reports a desire to be involved in the NAVIGATE program: ☐ Yes ☐ No

Client has a family that is willing to work with the NAVIGATE team: ☐ Yes ☐ No

Indicate **ALL** other services the referred individual has received for mental health in the past year (list all programs & outcomes as well as all hospitalizations/incarcerations for past year):

Name of Provider/Place:	How Long?	Outcome of Treatment/Placement

Referrer Information:

Name of Referring Person: _____ Referral Source (Agency Name): _____

Relationship to referred individual: _____ Phone #: _____ Email: _____

PLEASE INCLUDE COLLATERAL INFORMATION TO PROVE CRITERIA HAS BEEN MET: hospital admission and discharge summaries, medical records, psychiatric evaluations, etc.

Collateral information included? ☐ Yes ☐ No

Forward Completed Referral to:

Wesley Thrower, LMHC
wesleyt39@apalacheecenter.org
2236 Capital Circle NE Suite 104
Tallahassee FL 32308

*PLEASE NOTE THAT ADDITIONAL INFORMATION MAY BE REQUESTED PRIOR TO DETERMINATION FOR NAVIGATE TEAM SERVICES.