

Referral Screening

Patient name: _____

Date: _____

Yes	No	Currently taking psychotropic medication (Antidepressant, Antianxiety, Antipsychotic), or seeing a psychiatrist
Yes	No	Currently diagnosed with mental or emotional problems
Yes	No	Exhibiting sadness, anger, excessive worry
Yes	No	New diagnosis of debilitating condition within the past six months
Yes	No	History of cardiac problems, DM, thyroid dysregulation, chronic pain
Yes	No	Unexplained physical, cognitive, emotional, or other decline
Yes	No	Loss of loved one in the last 12 months
Yes	No	Exhibits help-seeking or demanding behaviors
Yes	No	Exhibits poor treatment adherence
Yes	No	In transition to new living arrangements
Yes	No	Struggling with resources (food, transportation, etc.)
Yes	No	Struggling with family discord

If “Yes” to any of the above items, please refer patient to CRS for further assessment.