Department of Mental Health
MIPSB Referral

Patient Name:

Guardian Name/Phone (if applicable):

Primary Language:

Area and Site of Tie:

Patient/Client Is Currently In:
( ) **Inpatient**
- Hospital/Unit:
- Date of Admission:
- Legal Status:
- Community Access/Privilege Level:
- Attending Psychiatrist:
- Psychiatrist Informed of this Referral?

( ) **Community**
- Address:
- Living Situation:
- Current Services:
- Psychiatrist:

Staff Contact Person:
Phone Number:

Case Manager (if applicable):
Phone Number:

Reason for Referral:

Diagnosis:
Axis I:
Axis II:
Axis III:

Medications:

Currently Adhering to Medications Prescribed: ( ) Yes ( ) No

Mental Status Currently Stable: ( ) Yes ( ) No

Number of Psychiatric Hospitalizations:
Number of Admissions to BSH:

Describe Baseline Mental Status:

Describe Current Level of Cognitive Functioning:

Age of Onset of Mental Illness:

Age of Onset of Problematic Sexual Behavior (if known):

Has Patient/Client Been Convicted of a Sex Crime: ( ) Yes ( ) No
If Yes, List Charges:

Is Patient/Client Required to Register with SORB: ( ) Yes ( ) No
If Yes, Have They Currently Met SORB Registration Obligations: ( ) Yes ( ) No
If No, Explain:
Level (if known):

History of Other Non-Sexual Criminal Behavior: ( ) Yes ( ) No
If *Yes*, Describe:
History of Non-sexual Violence: ( ) Yes ( ) No
If *Yes*, Describe:

DETAILS OF SEXUAL BEHAVIOR PROBLEM: (Please describe sexual behavior concerns and any additional known history of inappropriate and/or illegal sexual behavior. Include specifics when available such as behavior, convictions or charges and gender, age, relationship of patient to victim.)

Past Sex Offender Assessment: ( ) Yes ( ) No
If *Yes*, was this an MIPSB Assessment: ( ) Yes ( ) No
Past Treatment for Sexual Behavior Problem: ( ) Yes ( ) No
If *Yes*, When, Where And With Whom:

Additional Clinical Concerns for MIPSB Assessment:

Completed by:
Date: