

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
REFERRAL FOR CONVERSION FROM INPATIENT TO OUTPATIENT COMMITMENT
PURSUANT TO N.J.S.A. 30:4-27.15a(d)

This form is to be used when a patient who is involuntarily civilly committed to an inpatient unit is being referred to an involuntary outpatient commitment (IOC) provider.

REFERRAL TO IOC IS BEING MADE BY _____ (Name of Hospital)

Hospital primary contact information:

Telephone number:

Fax number:

CEO/CEO Designee: (Print) _____ (Sign) _____

IOC PROVIDER AGENCY: _____ in _____ County

DATE _____

PATIENT INFORMATION

NAME OF PATIENT: _____ COUNTY OF RESIDENCE: _____

D.O.B.: _____ SEX: F M SOCIAL SECURITY NUMBER: _____

LIVING SITUATION PRIOR TO HOSPITALIZATION: _____

PROPOSED LIVING SITUATION AND LOCATION OF RESIDENCE IN COMMUNITY IF CONVERTED TO IOC: _____

PRIMARY LANGUAGE SPOKEN: _____

PSYCHIATRIC/SUBSTANCE USE DIAGNOSES: _____

OTHER RELEVANT DIAGNOSES: _____

DATE OF ADMISSION TO PSYCHIATRIC HOSPITAL OR UNIT: _____

HOSPITAL WHERE PATIENT IS CURRENTLY BEING TREATED: _____

BUILDING/HALL/WARD ON WHICH PATIENT IS CURRENTLY BEING TREATED: _____

NAME OF TREATING PSYCHIATRIST: _____

CONTACT INFORMATION FOR TREATMENT TEAM: (Psychiatrist): _____

INSURANCE: _____ POLICY/GROUP NUMBER: _____

EMERGENCY CONTACT (relationship/phone number): _____

PRESENTING PROBLEM/REASON FOR REFERRAL

History of Hospitalizations:

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History of Non-compliance with outpatient services:

History of improvement with outpatient services:

Evidence of dangerousness to self/others (choose at least one, but describe all that are appropriate):

☐	Gravely disabled (cannot meet daily needs for self-care without help and such help is not available except through IOC). Describe:
☐	History of violence toward others/property. Describe:
☐	Threats of violence to others/property. Describe:
☐	Threats of violence to self. Describe:
☐	History of violence to self. Describe:
☐	Other. Describe:

SUBSTANCE USE HISTORY (this information is protected from disclosure by 42 CFR Part 2 and must not be further disclosed except with patient's consent or by court order)

Substance	Describe Use and Relevant Patterns

KNOWN LEGAL ISSUES? Y N

Describe:

RELEVANT MEDICAL ISSUES:

CURRENT MEDICATIONS: (include prescribing physician's name)

IS PATIENT CONSENTING TO MEDICATIONS (if not, explain)?

MOST RECENT/CURRENT COMMUNITY PROVIDER:

OTHER AGENCIES INVOLVED:

CONTACT PERSON (name and telephone number):

OTHER RELEVANT INFORMATION: (include other supports, e.g. family, religious organization, etc.)

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DISPOSITION OF REFERRAL

(IOC PROVIDER COMPLETES THIS PAGE AND RETURNS ORIGINAL TO HOSPITAL TREATMENT TEAM
AND COPY TO CEO WITH IOC PLAN)

ACCEPTED

___ CEO/CEO's designee notified on _____ by _____, _____
Date name title

___ Outpatient treatment plan drafted by IOC provider in collaboration with hospital treatment team is attached.

Name and contact information of IOC staff person who will serve as witness at a conversion hearing: _____

REJECTED

EXPLAIN REASON PATIENT CANNOT BE TREATED IN OUTPATIENT SETTING

BRIEF EXPLANATION: _____

