Name:_____ County: _____

ASSERTIVE COMMUNITY TRETMENT (ACT)
REFERRAL PACKET

THE REFERRAL PROCESS

Referrals to Assertive Community Treatment (ACT) teams will be accepted from professionals/providers of treatment and/or any other agency/hospital involved in the provision of Human Services. Individuals who are not enrolled in Magellan Behavioral Health services must be submitted to their county of residence (Lehigh or Northampton) for approval. The counties will than forward the referrals to the ACT provider.

ASSERTIVE COMMUNITY TREATMENT – CRITERIA FOR ELIGIBILITY

PART 1: Must meet ALL the Criteria in Part 1 to be eligible for ACT		
	Yes	**No**
Adult, 18 years of age or older		
Diagnosis: Primary diagnosis of schizophrenia or other psychotic disorders such as schizoaffective disorder, or bipolar disorder as defined in the DSM IV-R. Individuals with a primary diagnosis of substance use disorder, mental retardation, or brain injury are not the intended consumer group		
Difficulty utilizing traditional cases management or office based outpatient services or evidence that they require more assertive and frequent non-office based service to meet their clinical needs		
Functional level: Current GAF 40 or below ***Current GAF***:		
PART 2: Must meet two (2) out of the six (6) criteria in Part 2 to be eligible for ACT *(Check (✓) if "yes")*		
Two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months		
Intractable (persistent or very recurrent) severe major symptoms (affective, psychotic, suicidal)		
Co-occurring mental illness and substance use disorders more than six (6) months duration at the time of contact		
High Risk or Recent history of criminal justice involvement which may include frequent contact with law enforcement personnel, incarcerations, parole or probation		
Literally homeless, imminent risk of being homeless, or residing in unsafe housing		
Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring residential or institutional placement if more intensive services are not available		

ASSERTIVE COMMUNITY TREATMENT
ADMISSION REFERRAL FORM

Note: This form must be completed in its entirety and submitted with ALL supportive documentation: Psychiatric Evaluation, Copy of Current MA Card, Treatment History, Psychosocial History, GAF, a copy of Recent Lab Results, recent Progress Notes and any other documentation which will support the consumer's eligibility for Assertive Community Treatment team services. Whichever criteria the consumer meets must be supported by documentation or the referral will be incomplete and the assessment will not occur.

Date of Referral _____

I. General Consumer Information

Name (Last, First, Middle): _____

Maiden/ Other Name(s): _____

Address _____ County_____ Telephone_____

_____

Sex (circle one) Male Female Age: _____ Date of Birth: _____

Social Security Number: _____ Marital Status: _____

Primary Language: _____ Religious Affiliation: _____

Medical Assistance: Recipient Number _____ Category of Assistance: _____

If Currently Hospitalized: Name of Hospital: _____ Date Admitted: _____

Social Worker: _____ Telephone: _____ Projected D/C Date: _____

Interested Family Member or Friend: Name(s) _____

Address: _____

Telephone Number: _____

Presenting Problem: _____

_____

_____

Reason For Referral: _____

_____

_____

Has This Referral Been Discussed With the Consumer Yes _____ No _____

Has The Consumer Agreed? Yes _____ No _____

II. Identifying Information

Hair Color: _____ Eye Color:_____ Height:_____ Weight: _____

Glasses:_____ Contact Lenses:_____

Dentures:_____ Upper_____ Lower_____Needed

Hearing Aid:_____ Other Prosthesis:_____ Physical limitations: _____

III. Current Medical Information

Current Diagnosis: Axis I _____

II _____

III _____

IV _____

V _____

Psychiatrist: _____Address: _____ Telephone: _____

Community and State Hospital Admissions {List/Date any hospitalizations within the last 12 months}:

_____ _____

_____ _____

_____ _____

Current Medications/ Dosages/ Frequency: Requires Monitoring: ___ Yes ____No

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: Medication/ Substance _____ Reaction: _____

Clozaril Treatment { if applicable }:
Date began treatment: _____ Where: _____

Present Treatment Facility: _____ Dosage: _____

How is Clozaril being monitored at present? _____

Primary Physician: _____ Address: _____ Telephone: _____

Dentist: _____ Address: _____ Telephone: _____

Neurologist: _____ Address: _____ Telephone: _____

Other Doctor: _____ Address: _____ Telephone: _____

Current Medical Condition (Acute or Chronic medical problems). Current medications for medical problem, and family history of/or current medical problems: _____
_____
_____
_____

IV. Current/Previous Treatment History

Is there any current involvement with mental health services? Yes_____ No_____
If Yes, where _____ Contact Person _____

Length of Service: _____

Which County is involved with individual? _____

Total Number of State Hospital Admissions: _____

List prior treatment facilities (out-patient, partial hospitalization, etc…include outcome and consumer's participation): _____
_____
_____
_____

V. Drug and Alcohol History

Substances Used (frequency, evaluations, treatment, and treatment effectiveness for both family and consumer): _____
_____
_____
_____

VI. Financial Information

Source(s) of income:_____ _____ _____

Amount of Monthly Income:_____

Has SSI/SSD/MA Application been started? _____ By whom? _____

Other sources of income (include any Bank Accounts or Life Insurance Policies): _____
_____

Does individual have a Rep-payee: Yes___ No____ One is needed_____

If Yes, Name: _____ Address: _____

Relationship:_____ Agency: _____

Telephone: _____

Does individual have a Guardian? Yes ___ No____ One is needed_____

If Yes: Name: _____ Address: _____

Relationship: _____ Agency: _____

Telephone: _____

VII. Social History

Does individual have a secure living arrangement? Yes___No _____One is needed_____
If No, where is the individual currently living? _____

Describe any problems with past living arrangements? { ex. Past due rent, property damage, etc.}

_____

_____

_____

Where would the individual prefer to live? _____

Are these living arrangements possible/available? _____

Are there any family supports available? _____

Any family history of Mental Illness? _____ Yes _____ No If Yes, who _____

Any Criminal/Legal History? _____ Yes _____ No If Yes, explain _____
_____

History of behaviors {include when, toward whom, and if weapons were involved}:

Assaultive/ Aggressive _____
Homicidal _____
Suicidal _____
Physical Abuse _____
Sexual Abuse _____
Fire Setting _____

VIII. Educational/Vocational History

Completed Grade Level: _____ Any College or Vocational Programs? _____

Currently Employed? _____Yes _____No If Yes, Where _____
_____Part-Time _____Full-Time _____ Hours/Days working

Work History: _____

IX. Other relevant information about individual being referred for ACT and their need for ACT services?

Name of Person Completing Referral: _____

Agency/Hospital: _____

Date: _____