Northampton/Carbon Monroe Pike
Referral for EAC Consideration

Demographic, Identifying and Contact Information:

(All the following information is required to activate a referral) Date_____

Consumer Name: _____ DOB: _____

MA ID# : _____ SS#: _____

Last Known Address in the Community: _____

County of Residence: _____

Current Phone #'s: _____

Guardian Name: _____ Guardian Phone #: _____

Guardian Address: _____

BSU Case Manager: Name: _____ Phone #: _____

Facility making the referral? _____ Phone #: _____

Contact Name_____ Position_____

Referral discussed with consumer, guardian and/or family? _____

Member Response: _____

County Representative Contacted - Signature: _____

Please complete the following referral information as thoroughly as possible.

Current Symptoms:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Diagnosis

Axis I_____
Axis II_____
Axis III_____
Axis IV_____
Axis V Current_____ **Past Year**_____

Please attach most recent Psychiatric Evaluation.

Indicators of Continuous High Service Needs:

A. List Hospitalizations for mental health and substance abuse treatment in the last 12 months:
If coming from a hospital, please attach daily progress notes and/or Psychiatrist notes.

	Hospitalizations	Date of Hospitalization
1.		
2.		
3.		
4.		
5.		

B. List Incarcerations/Emergency Encounters/ in the last 12 months:

	Facility/Agency	Date(s) of Encounter
1.		
2.		
3.		
4.		
5.		

C. List the current services the consumer is involved with or has been referred to in the last 12 months, including case management:

	Type of service	# of contacts/week	Date Last Used	Outcome
1.				
2.				
3.				
4.				
5.				

D. List Substances Abused/Dependent:

	Type	Frequency	Date Last Used
1.			
2.			
3.			
4.			
5.			

E. History of life threatening suicide attempts/life threatening self-harm within past two (2) years.

List Specific Behaviors:

	Method	Date	Disposition
1.			
2.			
3.			
4.			

F. History of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to other within last 2 years (ex. Assault, rape, arson)

	Type of Impulsive/Acting Out Behavior	Type of Assault/Anger	Disposition
1.			
2.			
3.			
4.			

Potential Discharge Plan/Resource:

_____

_____

_____

Indicators of Consumer's Strengths and Supports"

A. Identify consumer's support system, including family, friends, social,community,

	List Supports and Relationship	Frequency of Contact
1.		
2.		
3.		
4.		

B. Identify Member Strengths:

1. _____
2. _____
3. _____
4. _____

Medical Conditions and Activities of Daily Living:

Medical Conditions:

1._____
2. _____
3. _____
4. _____
5. _____

Activities of Daily Living: Check all that apply

____Blind _____Hearing Impaired _____ Language Barrier ____ Independent with ADL's

____ ADL Dependent Explain_____

_____

Current Medications Name **Dose** **Frequency** **Reason**

1._____
2. _____
3. _____
4._____
5. _____

Additional Information: _____

_____

_____

_____

Team Meeting Date_____

Team member	Representing:

Discussion/Outcome:_____

_____

_____

_____

_____

_____

Actions Needed:_____

_____

_____

_____

_____

Does Consumer Have Advance Directive in Place? Yes ___ No ___ If yes, please provide.

_____

_____

_____

_____