Assertive Community Treatment (ACT)

Referral Form

835 South Burlington, #107
Hastings, NE 68901
(T) 402-462-4200
(F) 402-462-4201

REFERRAL SOURCE INFORMATION

Today's date:
Contact Person:
Agency:
Address:
Office phone: Office FAX:

PATIENT INFORMATION

Name:			Gender:
Address:	City:		Social Security #:
Phone:			
County of Residence:		US Citizen: Yes	No
Date of Birth:	Age:	Race:	Marital Status:
Ethnicity:	Preferred Language:		Veteran Status:
Health Insurance: **MANAGED CARE ORGANIZATION (Circle one)**	United Health Care	NE Total Care	Well Care

GUARDIAN	**PAYEE**
Name:	Name:
Address:	Address:
Phone:	Phone:

Does client and /or guardian agree to services? Y or N (circle one)
Comments:_____

Is there a Mental Health Board Commitment? Y or N (circle one) If Yes, from what county?_____

Comments:_____

Problem List: *Please include most recent IDI, MSE, and all hospital records with referral.*

	DX by:
	Facility:
	Date:

CRITERIA

Presence of SPMI for 12 months, or expected duration of 12 months with serious limitations in TWO of 3 Primary functional areas. Check if response is YES.

___ Vocational Skills
- ____ Does client need assistance to be consistently employed?
- ____ Does client require extensive supports in order to be employed?
- ____ Does client need assistance to pursue educational goals?

___ Social Skills
- ____ Does client have repeated inappropriate or inadequate social behavior?
- ____ Does client have difficulty in participating in adult activities?
- ____ Does client have a history of dangerousness to self or others?

___ ADLs

____Grooming	____ Hygiene
____ Med Management	____ Transportation
____ Nutritional needs	____ Care of Residence
____ Care of personal business affairs	____ Obtaining medical services
____ Obtaining legal services	____ Obtaining housing

____ Recognition and avoidance of hazards to self and possessions

____ Laundry

Is client at significant risk of continuing a pattern of living in a severely dysfunctional way if services are not provided and this pattern has existed or is likely to endure for one year or longer?
YES NO

Client has experienced multiple recent inpatient psychiatric hospitalizations? YES NO

Currently Hospitalized? YES NO Admission date (if applicable): _____

Past Hospitalizations: *Please include all hospital records from your facility.*

DATE	FACILITY	COMMENTS

REASON FOR REFERRAL: Why now? What is the presenting problem and why is it necessary for services now? How is the presenting problem impacting their mental health symptoms/recovery? What are the specific symptoms that are creating the need for these services?

_____

_____

_____

_____