# Upper Bay Counseling & Support Services, Inc.

## ASSERTIVE COMMUNITY TREATMENT (ACT)

## REFERRAL FORM

## The Referral Process

Referrals to Assertive Community Treatment (ACT) will be accepted from professionals/providers of treatment and/or any other agency/hospital involved in the provision of Behavioral Health Services. If you have any questions please call the Assertive Community Treatment Office at 410-996-3500 before completing the application.

## ASSERTIVE COMMUNITY TREATMENT -CRITERIA FOR ELIGIBILITY

Admission criteria: All of the following criteria are necessary for admission.

A. The consumer has a PBHS specialty mental health DSM-IV diagnosis included in the Priority Population, which is the cause of significant psychological, personal care, and social impairment.

DSM IV DIAGNOSIS

a. _____ Schizophrenia Disorder (295.00-295.99)
b. _____ Major Affective Disorder (296.00-296.89)
c. _____ Other Psychotic Disorder (297.00-298.90)

B. The impairments result in at least one of the following:

a. _____ A clear, current threat to the individual's ability to live in his/her customary setting, or the individual is homeless, and would meet the criteria for a higher level of care if Assertive Community Treatment were not provided.
b. _____ An emerging/impeding risk to self or others.

C. _____ It has been evidenced an inability to engage in traditional outpatient treatment due to symptoms of severe mental illness (not primarily drug abuse/dependence).

D. Inability to form a therapeutic relationship on an ongoing basis as evidenced by one or more of the following:

a. _____ Frequent use of emergency rooms for psychiatric reasons
b. _____ Frequent psychiatric hospitalizations (at least 3 in a year), or
c. _____ Arrest for reasons associated with the individual's mental illness.

E. _____ Individual's condition requires intensive, assertive mental health treatment and supportive services delivered by a multidisciplinary team, providing a minimum of weekly face-to-face contact.

## ASSERTIVE COMMUNITY TREATMENT

**Date of Referral:**

**Demographic Information**

Name (Last, First, Middle): _____

Maiden/Other Name(s): _____

Address: _____ City: _____ Phone: _____

Sex (Circle One) Male Female Age: _____ Date of Birth: _____

Social Security Number: _____-___-_____

Military Experience: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Okay to contact emergency contact in referral process? _____

Insurance Type: _____

Insurance #: _____

Has SSI / SSD / MA Application been started? _____ By Whom: _____

Income Source: _____ Monthly Amount: _____

TDAP: _____ Food Stamps: _____ Other Entitlements: _____

Completed Grade level: _____

Currently Employed? _____Yes _____No If yes, where? _____

_____part-time _____full-time _____hours/days working

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Reason for
Referral: _____

_____

_____

Has this referral been discussed with consumer? Yes_____ No_____

Has the consumer agreed? Yes_____ No _____

## If currently hospitalized:

Name of hospital: _____ Date admitted: _____

Social worker: _____ Telephone: _____

Projected D/C Date: _____

Psychiatrist: _____ Address: _____

Telephone: _____

Community and state hospitalizations (List/date any hospitalizations within the last 12 months)

_____

_____

_____

**Current/previous treatment history**

Is there any current involvement with mental health services? _____Yes _____No

Length of service: _____

Total number of State hospital admissions: _____

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

_____

_____

Current Medical Information

_____

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_____

_____

What are the client's current medical issues? _____

_____

Current Diagnosis (DSMV): Disorders and Conditions (Previously Axis I-III)

_____

_____

Important Psychosocial and Contextual Factors (Previously Axis IV) _____

_____

All Current Medications / Dosages / Frequency:

_____

_____

_____

_____

Requires Monitoring: _____Yes _____No

_____

_____

_____

_____

Is this individual on a long acting injectable medicine? _____Yes _____No If so, which injectable medicine and when was the last dose given? _____

Next dose due when? _____

Allergies /Medications / Substance: _____ Reaction: _____

**<u>Substance Use History</u>:**

Is client actively using? _____Yes _____ No _____Unknown

Substances used (frequency, evaluations, treatment, and treatment effectiveness for both family and consumer)

_____

_____

_____

_____

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_____

**Social History:**

_____
_____
_____
_____

**Legal History: (**probation or parole officer, any pending charges etc**.)**_____
_____
_____
_____

**Community Supports**: (Identify any support systems client may have family, friends etc.)

_____
_____
_____

**Please forward all completed referral forms and supporting documents to:**

ACT Program Director

UBCSS

200 Booth Street Elkton, MD 21921

Or fax to 443-406-7561

Name of person completing referral _____

Contact Phone Number: _____

Agency/Hospital: _____

Date: _____

Date Received: _____

Disposition of Referral:

_____

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