

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-V diagnosis included in the Priority Population, which is the cause of significant psychological, personal care, and social impairment.

DSM V DIAGNOSIS- DIAGNOSIS DATE _____

- 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.

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- 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: _____

Insurance Type: _____ MAP #: _____

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 AND Date of diagnosis/diagnoses (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: _____

Substance Use History:

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 _____ Phone#: _____

Agency/Hospital: _____

Date: _____

Date Received: _____

Disposition of Referral:

Upper Bay Counseling & Support Services, Inc.

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