Carbon/Monroe/Pike Health Choices
Referral for

Fax to Community Care at 1-866-562-2405 Or Email to whitevl@ccbh.com

Demographic, Identifying, and Contact Information:

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

Client Name: ____ DOB: ____________

MA ID#: ________________________________ SS#: ______________________________

Current Address: ____

Current Phone #'s: ____

Case Manager: Name: ____________________________ Phone #: _____________________

_Email Address:_________________________________

Who is making the referral? ________________________ Phone #: _____________________

Facility______________________ Email address: ______________________________

Referral discussed with consumer, guardian and/or family? Yes or No

Response: ____

Primary Language Spoken: ____

Release of Information Signed for Community Care, and Project Transition, if approved. Yes No

Please complete the following referral information as thoroughly as possible.

Admission Criteria

I Diagnosis:

The person must have a primary diagnosis of a serious and persistent mental illness and/or co-occurring substance use disorder and/or a dual diagnosis of an intellectual and developmental disAbility.

List Current Diagnosis, Medications and GAF Score (All Required)

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Medications	Dose	Frequency

II. Indicators of Continuous High Service Needs:

List Hospitalizations for mental health and substance abuse treatment in the last 12 months

Facility/Hospital	Dates	Outcome/Disposition

List Incarcerations/Emergency Encounters

Incarceration/Crisis Provider	Date of Encounter

B. Has the consumer demonstrated an inability to participate in OR remain engaged in OR respond to traditional community-based services?

List the current services the consumer is involved with or has been referred to in the last 45 days including case management:

Type of service # of contacts/week Date Last Used Outcome

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

List Services in Last Year:

Type of Service | # of contacts/week | Date Last Used | Outcome

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

C. Please complete in detail the categories that apply.

1. Is there evidence of current, co-existing mental illness and substance abuse/dependence?

List Substances Abused/Dependent:

Type | Frequency | Date Last Used

1. ____

2. ____

3. ____

4. ____

2. Is there any 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. ____

3. Is there any history of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to another person within last 2 years (ex. Assault, rape, arson)

List Behaviors:

Type of Impulsive/Acting Out Behavior	Type of Assault/Anger	Disposition/Outcome

1. ____
2. ____
3. ____
4. ____

4. Is there a lack of a support system: limited or no support from family, other professionals, friends, social programs?

☐ No Supports ☐ Limited Supports- List in Section IV.A

5. Is there a history of inadequate follow through with elements of a Treatment Plan that results in consumer's Psychiatric or medical instability (including lack of follow through taking medication, following a crisis plan, attending to health needs or maintaining housing)?

List any Behaviors Indicating Lack of Follow Through	What Happens

1. ____
2. ____
3. ____
4. ____

6. Are there any current or history of command hallucinations regarding harm to self or others with inability to ignore?

List: Hallucinations and indicate if they are directed towards self or others and explain how these influence the consumer

____

____

____

____

7. Have there been any threats of physical harm to others with or without follow through behavior within past two (2) years?

List:
Threat — If follow-through, Method of Follow Through

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

8. Is there current homelessness resulting in the person living on the street, in a shelter or substandard housing. (OR)

The individual is residing in a state operated inpatient bed or maxed out on time served and in a Facility/institution on the state inpatient diversion list or a supervised community residence but *clinically assessed* to be able to live in more independent living if intensive services are provided or to prevent admission to a more intensive level of care.

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____
____

III. Functional Level –

Current GAF: ____________

IQ score: __________

Additional Information:

IV. Indicators of Consumer's Strengths, Supports, and Educational/Vocational History:

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. ______________________________

C Educational/Vocational History:

List Education and Vocational History

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

V. Medical Conditions Activities of Daily Living:

A. Medical Conditions:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

B. Activities of Daily Living: Check all that apply

____Visually Impaired ______Hearing Impaired ______ Language Barrier

____ Independent with ADL's Primary Language:__________________________

____ ADL Dependent Explain: ______________________________

____

Additional Information: ______________________________

____

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____

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Outcome of Community Care Review: Date:________

Outcome:

____Not approved; Referral Source Notified on __________

____Approved for Referral to PT for tour and assessment

Referral Faxed on: _______

____Interview/Tour Completed on: _________ PT Decision: ________________________

___ Referral source notified of final decision, by Community Care on: _______

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