ADULT MENTAL HEALTH RESIDENTIAL PROGRAM
REFERRAL FORM
for
PROJECT TRANSITION

DEMOGRAPHICS

MEMBER NAME: _____ **SOCIAL SECURITY #:** _____

ADDRESS:_____ **PHONE:**_____

AGE: _____ **DOB:** _____

CURRENT LIVING ARRANGEMENT: _____**CONTACT:** _____**PHONE:** _____
(family home; shelter; homeless, safe haven, etc.)

REFERRING PROVIDER

REFERRING FACILITY/AGENCY: _____ **LEVEL OF CARE**: _____
(Acute inpatient, Sub Acute; Rehab, BHJRS, DHS, OP, CIRC, etc.)

REFERRING AGENCY CONTACT: _____ **TITLE**: _____

PHONE # :_____ **EMAIL:** _____

FAX #: _____**(required)**

***WHO TO CONTACT TO START ADMISSION**: _____ **PHONE:** _____
(member, referring agency; OPT; shelter placement, etc.)

OUTSIDE AGENCY INVOLVEMENT

CASE MANAGER: _____ **AGENCY:** _____ **PHONE #:** _____

DHS/CUA WORKER: _____ **PHONE #:** _____ FAX **#:** _____

PROBATION/ PAROLE OFFICER: _____**PHONE #:** _____ **NCD:** _____

Please submit the following documents listed below via encrypted email to CBHCSS@phila.gov or securely email documents to your CBH care manager.

- ☐ Completed Adult Mental Health Residential Referral ***This Form***
- ☐ Completed Comprehensive Biopsychosocial Evaluation (CBE/CBR)
  - ☐ Must be signed by a licensed psychiatrist/psychologist and dated within the past 6 months
  - ☐ Psychiatrist/psychologists name and credentials clearly printed
  - ☐ Legible
  - ☐ Clinical history, diagnosis, mental status exam and recommendation for Adult Mental Health Residential (Project Transition)

Clinical Rationale

1. Check domains most impacted by member's mental health challenges:

☐ Living
☐ Learning/Education
☐ Working
☐ Social

2. Check applicable history below:
   ☐ Intellectual disability IQ: _____
   ☐ Cognitive disorder
   ☐ Traumatic brain injury

3. Check and briefly describe the member's needs in at least two of following areas:

   Social skills (interpersonal skills, boundaries, self-esteem, social problem solving, following rules/obey laws, avoiding being victimized, elopement, challenging sexual behaviors):

   Practical skills (personal care, laundry, occupational skills, medication management, managing healthcare, travel/transportation, schedules/routines, safety, budgeting, use phone):

   Conceptual Skills (self-directed care, expressive language, processing and understanding concepts, following directions, emotional regulation):

4. Briefly describe any active/history of substance use:

5. Project Transition has a 24 hour coaching line but no live-in staff. Is the member able to live safely in an apartment community without 24 hour supervision? (Please consider if the member has basic safety awareness/self-preservation skills; any history of aggression towards others in the last 2 years). Please explain:

6. Briefly describe adaptive strengths used in previous living situations (i.e. can cook; groom self; clean; grocery shop; launder clothes; budget; make/keep appointments; work/volunteer/attended school; take medications as prescribed, etc.):

7. **Project Transition** treatment **requires attending all day group sessions** and **weekly individual therapy sessions** with various clinical staff and **following all program rules as expected**. Indicate if the member agrees to this level of structure and is motivated to contribute to his/her treatment process at Project Transition? Please circule - Yes/No: