HealthChoices Referral for

Send via SECURE e-mail to Clinton/Lycoming Community Care at
shadlec@ccbh.com AND bakerr5@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 #: _______________________

Who is making the referral? ___________________________ Phone #: _______________________

Facility__________________________

Referral discussed with consumer, guardian and/or family? ________________________________

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

The individual must be over the age of 18 and meet the following:

I Diagnosis:

The person must have a primary diagnosis of Schizophrenia or other Psychotic disorder or Chronic Major Mood Disorder; SPMI, including dual diagnosis(MISA) and Personality Disorders

List Current Diagnosis (DSM 5/ICD 10) and Medications (All Required)

Behavioral Health: ____

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

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

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

Evidence of current, co-existing mental illness and substance abuse/dependence.

List Substances Abused/Dependent:

Type   Frequency   Date Last Used

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

Additional Information:

Medical Conditions and 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: ____

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Additional Information: ____

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