**Referral Form**

Individual’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Known Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_Gender: M/F Medicaid/Member ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REASON FOR REFERRAL -** *Why does this individual need this service?*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS:**

Name Dose Compliance

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

**Serviceable Problems: (circle)**

**Difficulty with basic functioning Substance Abuse Cognitive Functioning**

Nutrition Currently Intoxicated learning new skills

Medication management History of Substance Abuse completing tasks

dressing/hygiene Recent Detox reading/writing

medication management Alcohol/Drug Abuse current prioritizing activities

**Sleep Patterns Social Functioning**

difficulty falling asleep maintaining close friendships

difficulty staying asleep understanding social rules of conduct

Nightmares involved in social/recreational/religious activities

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**CURRENT SERVICES**: (*List current services being received such as in-home counseling, case management, therapy etc.):*

|  |  |  |
| --- | --- | --- |
| **Type** | **Provider** | **Dates Provided** |
|  |  |  |
|  |  |  |
|  |  |  |
| **Transfer/Add Service** |  |  |

**Community Based Admissions Criteria**

**Individual Must Meet One for both IIH or MHSB:**

\_\_\_\_ The dx(es) must support the recent significant functional impairments in major life activities.

\_\_\_\_The impairments experienced by the member are to such a degree that they meet the criteria for being at risk of out of home placement as defined in the below section.

**MEET TWO for IIH or MHSB:**

\_\_\_\_\_ Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization \*or out-of-home placement\*\*because of conflicts with family or community.

\_\_\_\_\_ Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary resulting in being at risk for out of home placement.

\_\_\_\_\_ Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior resulting in being at risk for out of home placement.

\_\_\_\_\_ The individual requires help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health and safety is jeopardized.

**IIH Criteria: MEET ONE:**

**\_\_\_\_\_**Risk for out-of-home placement, as these terms are defined in this section:

\_\_\_\_ Services are far more intensive than outpatient care are required to stabilize the individual in the family or

\_\_\_\_\_ The individual's residence as the setting for services is more likely to be successful than a clinic.

**Family Involvement** **MEET BOTH:**

\_\_\_\_ At least one parent/guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family.

\_\_\_\_ A responsible adult shall be an adult who lives in the same household with the child and is responsible for engaging in therapy and service-related activities

 **MHSB Criteria: Must meet ALL THREE of the following on a regular basis: (on-going)**

* Diagnosis of a SMI such as: Schizophrenia, bipolar, major depressive disorder
* History or psychiatric hospitalization, ICT or PACT services, or psychiatric residential services
* Prescribed psychotropic medications in the past 12 months

**COMMUNITY STABILIZATION Criteria: Must meet TWO**

* The individual is stepping down from a higher level of care after a recent behavioral health crisis and needs continued stabilization prior to returning to the community
* Suicidal thoughts or behaviors and/or recent self-injurious behavior with suicidal intent
* Individual does not have the ability and/or the resources to support maintenance of safety and/or stability in the community until longer term services are available/accessible or mobilized
* Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community

**PARTIAL HOSPITALIZATION PROGRAMS**

**Substance Abuse Partial Hospitalization Program Criteria:**

* No withdrawal Minimal Risk of severe withdrawal (ASAM Level 2.1)
* Moderate risk of severe withdrawal (ASAM Level 2.5)
* No withdrawal risk, or minimal or stable withdrawal (ASAM Level 3.1)
* At minimal risk of severe withdrawal (ASAM Level 3.3 or 3.5)
* ASAM LEVEL 3.7 ONLY: Patient has the potential for life threatening withdrawal (must meet at least two of the six dimensions, at least one of which is within dimension 1, 2, or 3)

**Mental Health Partial Hospitalization Program Criteria:**

* The individual must have a DSM Diagnosis consistent with the DSM-5
* The individual must be at risk for inpatient hospitalization
* The individual can attend all groups
* Severity of symptoms can’t be managed in a less intensive environment

**DESCRIPTION ASSIGNED TO: DATE SCHEDULED**

**QMHP**

**Housing**

**Substance use resource**

**Other IMMEDIATE Needs/ASSESSMENT**

**MCO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date verified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person verifying: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Copayment/Out of Pocket Expense (If Applicable): \_\_\_\_\_\_\_\_\_\_ Individual Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Active Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSON COMPLETING FORM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**