Act Program Purpose: Adult ACT serves individuals over the age of 17 who have a mental illness listed in the most current DSM that seriously impairs their functioning in community living. **Priority is given to individuals with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder, or major/chronic depression,** as these illnesses more frequently cause long-term psychiatric disability. Priority is also given to individuals with continuous high service needs that are not being met in more traditional site-based service settings. **Individuals without active Medicaid should not be excluded from eligibility** but additional funding is necessary for ACT services (Safetynet). Individuals with a primary diagnosis of a personality disorder(s), SUD, or intellectual/developmental disabilities are not appropriate for ACT.

Referral to Assertive Community Treatment

Mark Appropriate Admission Criterion- (minimum of 7 need to be met to be considered):

_____ 1. Be at least 17 years of age
_____ 2. Has a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, borderline personality disorder or major depressive disorder
_____ 3. Co-occurring, developmental disability, personality disorder, or organic disorder diagnosis is ***NOT*** listed as primary diagnosis but can be secondary or tertiary, etc.
_____ 4. Medically stable and does not require more intensive medical monitoring
_____ 5. Unable to participate in traditional office-based services
_____ 6. Lives independently or is homeless but demonstrates a capacity and desire to live independently in the community with additional combined mental health and basic living supports to prevent need for highest level of care
_____ 7. In the last year has had two or more psychiatric hospitalizations OR
_____ 8. In last year has had two or more psychiatric ER visits OR
_____ 9. In last year has had two or more access center or visits by mobile crisis team OR
_____ 10. Has been incarcerated two or more times within the last ***two*** years
_____ 11. Demonstrates a need for multiple combined mental health and basic living supports to prevent the need for more intrusive level of care
_____ 12. Has intractable (i.e., persistent or recurrent) severe major symptoms (e.g., affective psychotic, suicidal, self-mutilation)
_____ 13. Is not adhering to medications as prescribed
_____ 14. Presents a low risk to self, others, or property, with treatment and support
_____ 15. Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided

Act Referral Cont.

Referral Provider: _____Agency: _____Contact Phone #_____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____

Address(street, city, zip code): _____

Home Phone: # _____ Cell Phone: # _____ DOB:____/___/_____

Sex: _____ Race: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Insurance Type & #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Clinic Name: _____ Phone: _____

Current Type of Housing (e.g., group home): _____

Veteran: ☐Yes ☐No Potential Transportation Issues? ☐Yes ☐No

CLINICAL INFORMATION

Reason for Referral: _____

_____

Primary Psychiatric Diagnosis:_____

Secondary Psychiatric Diagnoses (including substance abuse): _____

Medical Diagnoses:_____

_____

Relevant Social Factors: _____

_____

Past Psychiatric History (hx) and Treatment (please check appropriately)

Hx of violence? ☐No ☐Yes, details_____

Hx of suicide attempts? ☐No ☐Yes, details _____

Hx of psychiatric hospitalizations? ☐No ☐Yes, details _____

Previous/current symptoms: _____

Current Treatment and or Symptoms: _____

Current suicidal/homicidal thoughts? ☐No, ☐Yes, details:_____

Current mental health provider? ☐No ☐Yes, details: _____

_____

Current Medications (name, dose, pharmacy, attach list if preferred):_____

_____

_____

Current or Previous Legal Concerns:

Current or history of legal problems? ☐No ☐Yes, details_____

Current or previously ordered to mental health or substance use disorder treatment? ☐No ☐Yes, details:_____

Probation or Parole officer?(Name, Phone number): _____

Other concerns?:_____

_____

Signature of Referral Source: _____ Date:_____

Please send referral from to: referrals@pamhc.org