New Directions® Northwest Inc.

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Chief Executive Officer: Shari Selander

New Directions for Positive Changes….
"Specializing in helping people with Alcohol, Drug, and Gambling Addictions, Mental Health, Developmental Disabilities and Prevention."

Assertive Community Treatment

REFERRAL FORM

Assertive Community Treatment (ACT) is an Evidence-Based Practice designed to provide comprehensive outpatient treatment and support services, through a wellness and recovery approach to individuals diagnosed with serious mental illness. ACT services are provided by a multidisciplinary team with an aim to maximize independence and community integration. ACT provides a variety of services, delivered within the home and community, as well as office settings to support recovery and reduce or prevent inpatient hospitalization. Services **may** include skills training, psychiatric prescriber, medication training and support, individual and/or group mental health counseling, case management, peer support, supported employment, and co-occurring substance abuse treatment; all dependent upon individual needs.

REFERRAL INFORMATION

Name:_____ Primary Clinician:_____ Date of Referral:_____

Email:_____ Phone: _____

Insurance Information: EOCCO DMAP Medicare Other

Reason for referral at this time (Select all that apply):

No mental health care ☐ Has services, needs higher level of mental health support ☐

Failed other levels of care ☐ Has multiple psychiatric admissions in the past 12 months ☐

Other:_____

Is person interested in ACT services? Yes ☐ No ☐ If no, why?_____

_____

Is the family/support system interested in ACT services? Yes ☐No ☐ If no, why?_____

_____

CURRENT CLINICAL INFORMATION

Current Clinical Presentation (predominant symptoms):

The ACT Model was designed for those clients who traditional OPS have not been successful in preventing or reducing repeated hospitalizations, involvement with the judicial system, and homelessness. Please explain what interventions have been used and there outcomes.

Is the person currently experiencing psychosis? Yes ☐ No ☐
Current Diagnosis (can list multiple dx):

Is the person currently prescribed psychiatric medications? Yes ☐ No ☐

Does the person take these as prescribed? Yes ☐ No ☐ If no, what are the barriers?

Current Substance Use

Substance	Frequency of Use

Is the person currently engaged in any treatment? Yes ☐No☐If no, what are the barriers to engagement?

If yes, what services are they currently engaged in? (Please select all that apply)

	Provider Name	Organization (Location)	Phone/Fax
Psychopharmacology (meds)			
Therapy			
Group(s)			
Substance Abuse			
Other:			

Does this person currently have any of the following? (Please select all that apply. If yes, please provide more detail):

Suicidal ideation:_____

Homicidal ideation:_____

Access to weapons:_____

Guns in the home:_____

Aggression/Violence:_____

HISTORICAL/CLINICAL INFORMATION

Prior levels of care engaged in (please select all that apply):

Psychiatric inpatient☐Residential/Group Home (if known, please indicate name) ☐ _____

Continuing care (state hospital)☐# of prior (lifetime) psychiatric inpatient admissions:_____

Most recent (date & name of facility):_____

Has this person ever had any of the following (Please select all that apply. If yes, please provide more detail with date if known):

Psychosis ☐ _____

Suicidal ideation ☐ _____

Suicide attempts ☐ _____

Homicidal ideation ☐ _____

Is there a family history of mental illness? Yes☐No☐_____

Please indicate relation to person and their diagnosis:_____

History of Homelessness?Yes☐ No ☐If yes, when were they last homeless?_____

REFERRER RECOMMENDATIONS

How many months do you estimate this person needing ACT level of services?_____

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Has the person responsible for the financing approved ACT service?_____

REFERRAL ACCEPTANCE/DENIAL/WAITLISTINFORMATION

ACT Team Determination& Date:

Accepted_____Denied_____ Waitlisted_____

If denied, reason for denial and tx recommendations:

Notification of primary clinician:

Date notification was sent: _____ Mode of notification: _____