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**MHSS Referral Form**

**Today’s** **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral** **Source**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring** **Agency**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referral** **Source** **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason** **for** **Referral**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client** **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client** **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do you have Medicaid? Yes / No** (circle)

**Medicaid** **Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social** **Security** #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Monthly** **Income**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The** **individual** **must** **meet the following criteria**. **Please indicate Yes or No:**

Member must have one of the following: psychotic disorder, major depressive disorder – recurrent, or bipolar disorder I or II Any other Axis I mental health disorder that a physician has documented specific to the identified individual within the past year to include all of the following: (i) that is a serious mental illness; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual’s major life activities that are documented in the individual’s medical record, AND; (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community.\_\_\_\_\_\_\_\_

The individual shall have a prior history of any of the following: psychiatric hospitalization; residential crisis stabilization, ICT or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or TDO pursuant to the Code of Virginia §37.2-809(B) evaluation as a result of decompensation related to serious mental illness.\_\_\_\_\_\_\_\_\_\_

**If yes,** **please indicate where the prior history occurred, I.E name of hospital etc.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The individual shall have had a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the assessment date. \_\_\_\_\_\_\_\_\_\_\_

The individual shall require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management. \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are** **you** **currently** **receiving** **MHSS**? \_\_\_\_\_\_\_\_\_\_\_ **Agency**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are** **you a** **returning**/**past** **client**? \_\_\_\_\_\_\_\_\_\_\_\_

**Are** **you** **currently** **in** **crisis** **intervention** **or** **crisis** **stabilization**? \_\_\_\_\_\_\_

**Do** **you** **have** **specialized** **ambulation** **needs**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently hospitalized?** \_\_\_\_\_\_\_**Location**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discharge** **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you receive case management from the CSB?\_\_\_\_\_\_\_\_\_**

**Case Manager Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manger Contact Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax referral form to 757-299-1921**

**Intake Coordinator Sheri Baker 757-751-4011**

**Office Staff Only**

Was the referral accepted?\_\_\_\_\_\_\_\_\_\_\_\_\_

If declined, where was s/he referred?­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason declined? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake Coordinator Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_