

**Straight Walk Family Services**

**ACTT REFERRAL FORM**

*Fax all referrals to 252-210-3415*

Referral Agency: Referral Date: Referral Phone: Relationship to Client: Client Legal Name: Preferred Name: Social Security # DOB Age

* Male ☐ Female ☐ Pregnant ☐ IV drug user

Client Phone: Alternate Client Phone: Physical Address:

Legal Guardian: Phone: Address: Marital Status: ☐Single☐Married☐Separated☐Divorced☐ Widowed ☐ Domestic Partners

Living Arrangement: ☐ Adult Care Home ☐ Homeless/shelter ☐ Private Residence ☐ Other Insured Name: DOB: Relationship to Insured: Insurance: Benefits Verification Phone:

Insured ID # Group #

* Copy of front and back of card attached

Insured Employer: Medicaid# Medicare#

County: ☐ IPRS/Uninsured **Services**

What mental health services is the client currently receiving?

Has the client previously tried a level of service lower than ACTT?   Yes  No

If yes, which service(s)?

**Diagnoses**

Has the client ever been diagnosed with a psychotic or mood disorder?   Yes  No

If yes, what disorder?

Note any severe psychiatric symptoms.

Has the client ever been diagnosed with a personality disorder?  Yes  No

If yes, what disorder?

Has the client ever been diagnosed with mild or moderate mental retardation?  Yes  No

History of substance use?  Yes  No

Substance of choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Abuse/Dependency/Treatment:

Positive Drug Screens ☐ Yes ☐ No Positive for:

**Medical**

Current medications ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication history:

Is the client currently on any injectable medications?  Yes  No if yes, name of medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previously hospitalized for psychiatric reasons? Agency and dates, if known::

Primary Care Physician

What medical concerns does the client have? \_\_\_\_\_

* Danger to self or others History of: ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Legal issues☐History/Current of aggressive behaviors Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social**

Has the client ever had any legal charges?  Yes  No

If yes, list charges with dates.

What is the client’s current living situation (homeless, surfing, group home, shelter, substandard housing)? What problems has the client experienced in maintaining housing?

**Additional ACT Criteria**

Does the client have SSI or SSDI?  Yes  No

Does the client have difficulty performing daily living tasks?  Yes  No

Is the client currently unemployed or experiencing issues with work?  Yes  No

Explain:

Does the client have problems getting medical services or making medical appointments?  Yes  No

Does the client have trouble avoiding common dangers to himself/herself?  Yes  No

If yes, please describe.

Does the client have any eating or nutritional concerns due to mental health symptoms?  Yes  No

If yes, please describe.

Is the client able to maintain his/her own finances and business affairs?  Yes  No

Does the client maintain his/her personal hygiene daily?  Yes  No

Other notes that may be relevant to ACTT:

|  |
| --- |
| Signature of clinician completing form:  Signature of psychiatrist: |