Straight Walk Family Services
ACTT REFERRAL FORM
Fax all referrals to 866-441-1189

If you or the client is in a state of crisis or need immediate help for any reason, please refrain from filling out this referral and call 911. If you feel that you are a danger to yourself or others, please refrain from filling out this referral and call or text 988.

Referral Agency: _____ **Referral Date:** _____
Referral Phone: _____ **Relationship to Client:** _____
ReasonforReferral:

_____

Client Legal Name: _____ Preferred Name: _____
Social Security # _____ DOB _____ Age_____
Name: _____ DOB:_____
Relationship to Insured: _____ Insurance: _____
Benefits Verification Phone: _____
Insured ID # _____ Group #_____

☐ Copy of front and back of card attached

☐ 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
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
Has the client ever been diagnosed with traumatic brain Injury? ☐ Yes ☐ No
If yes, what disorder? _____

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: _____

Consent to Release Information (if applicable):

☐ Client has consented to this referral and information exchange

☐ Release of Information attached

Submit referrals to:medicalrecords@straightwalknc.com and/or christina@straightwalknc.com

Signature of referral source completing form: _____

Signature of psychiatrist: _____