MaineHealth

MAINE BEHAVIORAL HEALTHCARE - ACT REFERRAL

CLIENT CONTACT INFORMATION

CLIENT NAME Last: ______________________________First: _________________ MI: ____

ADDRESS (please check ❑ if unhoused):
____

PHONE NUMBER(S): _____________________________ DATE OF BIRTH: ________________

PARENT OR GUARDIAN NAME: ______________________RELATIONSHIP TO CLIENT:________________

ADDRESS: ____

PHONE NUMBER(S): ________________________________ Okay to leave a message? ❑ YES ❑ NO

Special calling instructions (language type if necessary): _______________________________________

REFERRED BY:

Print Name _______________________ Tel No:________________ Fax No: :________________

Person referring email: ______________________________ Referral diagnosis date: _____________________

Diagnosis description/and by whom including their credentials: ___________________________________

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If the primary diagnosis is not schizophrenia or schizoaffective disorder, use the requirements listed here to complete the clinical rationale; please include the functional impairments that are directly related to the primary diagnosis.

Clinical Rationale: _____________________

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Requirements for ACT

1. Primary Diagnosis of Schizophrenia or Schizoaffective disorder that causes serious functional impairment

OR

2. Another Primary DSM diagnosis with a clinical letter justifying the need based on a combination of the following significant risk factors and serious functional impartment:
   a. Homelessness
   b. Criminal Justice Involvement
   c. Significant medical needs that aren't being addressed due to mental health
   d. Has received treatment in a state psychiatric hospital within the past 24 months
   e. Has had 2 or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode within the past 24 months
   f. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis with a LOCUS of 17 or greater
3. **Exclusionary Criteria: Primary diagnosis IS NOT Borderline Personality Disorder, Anti-social Personality Disorder, Neuro-Cognitive Disorders, Neuro Development Disorders, Substance Use Disorder**

LOCATION: ❑ Biddeford ❑ Brunswick ❑ Portland ❑ Springvale Each location has a 25-mile radius catchment area

GUARDIAN CONTACT INFORMATION

Guardian name: ____Relationship to client: _________________________________

Address: ____

Phone number: ____ Okay to leave a message? ❑ YES ❑ NO

LIST ALL MENTAL HEALTH SERVICE PROVIDERS AND CONTACT INFORMATION

Name	Service Type	Location

Psychiatric hospitalizations within the past two years:

Begin Date	End Date	Hospital

Lower levels of service that the client has utilized and not been successful with:

Begin Date	End Date	Location

Current medication list (complete below or attach list):

Medication Name	Dose

[Safety Concerns] Criminal Justice Involvement:

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Is there a concern about access to weapons? ❑ YES ❑ NO Are there Firearms in the home? ❑ YES ❑ NO

Are the firearms safely stored? ❑ YES ❑ NO

Please fax the completed form to 207-661-8559