



ACT WEB REFERRAL FORM

**250 East Fayette Street
Uniontown, PA 15401
Fax: (724) 437-3221**

Name: _____

DOB: _____ **Age:** _____ **SSN:** _____ **Gender:** _____

Address: _____

Phone #: _____ **Ethnic Origin:** _____ **Marital Status:** _____

Education: _____ **Occupation:** _____ **Income:** _____

Insurance: _____ **Insurance ID:** _____

Case Manager: _____

Reason for Referral:

Diagnosis: **Problem 1:** _____
Problem 2: _____
Problem 3: _____
Problem 4: _____
Problem 5: _____

Current Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Treatment:

Facility: _____

Doctor: _____ **Therapist/Social Worker:** _____

Significant Medical Conditions:

Substance Abuse Issues:

Legal Issues:

Family/Support Individuals:

Other Agency Involvement:

Referral Source: _____

Phone #: _____ **Date:** _____

Individual NPI #: _____ **PA Promise Medicaid #:** _____

Treatment/Social History (Check all that apply):

- 2 or more acute psychiatric hospitalizations within the past year
- 30 days or more of a psychiatric hospitalization within the past year
- 3 or more face-to-face crisis/emergency contacts within the past year
- Homeless, as defined by sleeping in shelters or places not meant for human habitation or at-risk for repeated evictions or loss of housing
- Placed on probation, parole or in a jail diversion program within the past 6 months or at-risk for involvement with the criminal justice system
- A co-existing substance abuse disorder of more than 6 months
- History of inability to participate in traditional office-based services despite documented efforts to engage the individual by a recognized mental health professional or case management provider, as evidenced by:
 - at least 3 missed mental health appointments within the past 6 months
 - documentation that the individual has not followed prescribed medication regime
 - history of court ordered treatment
 - documentation that the individual has not benefited from ICM services

Functional/Service Needs (Check all that apply):

- Basic self-care skills, activities of daily living
- Symptom/illness management
- Housing/household maintenance
- Social / interpersonal / leisure / recreational
- Family education and support
- Substance abuse management
- Educational / vocational support
- Financial management
- Legal support
- Other: _____

The individual is interested in and chooses to receive ACT services at this time.

- Yes No

Signature: _____

Date: _____

Admission Committee Review Date: _____

Status:

- Accepted

Doctor's Signature: _____

- Not Accepted

Reason for Not Accepted:
