MAINE BEHAVIORAL HEALTHCARE

Record Number

ACT REFERRAL FORM

CLIENT NAME:_____ BIRTHDATE:_____ DATE:_____

Person Making Referral: _____ Agency: _____

Agency's Telephone #: _____ Client Social Security #: _____

Client Address: _____ Maine Care: YES ____ NO ____

City: _____ Telephone: _____

State: _____Zip:_____

Reason for referral (please review and check the criteria that apply):

ACT Eligibility Criteria (clients must meet both #1 and #2)

□ **1.** Diagnosis of Schizophrenia or Schizoaffective Disorder or another DSM5 Diagnosis and:
- □ a. Documented or reported history that he or she would have future episodes of homelessness, criminal justice involvement or require mental health inpatient treatment for more than 72 hours based on symptoms of mental illness, OR
- □ b. Has received treatment in a state psychiatric hospital within the past 24 months, OR
- □ c. Has been discharged from a mental health residential treatment facility within the past 24 months, OR
- □ d. Has had two or more episodes of inpatient treatment for mental illness, greater than 72 hours per episode, within the past 24 months, OR
- □ e. Has been committed by a civil court for psychiatric treatment as an adult, OR
- □ f. Until the age of 21, he or she was eligible as a child with severe emotional disturbance and have risk factors for mental health inpatient treatment or residential treatment

□ **2.** Lower levels of treatment have not been effective at keeping client stable

Please provide specific documentation supporting all selected above.

Is the client aware of the referral? If so, how do they feel about this referral to ACT?

_____

_____

_____

Please list all current behavioral health providers and confirm all providers aware of this referral to ACT:

_____

_____

_____

Current medications (please attach current medication orders):

_____

Diagnosis and current symptoms:

_____

_____

_____

PLEASE FAX THIS COMPLETED FORM TO THE ACCESS CENTER AT: 207-661-6370