**MENTAL HEALTH SKILL BUILDING SERVICES - REFERRAL STATEMENT**

Date of Initial Contact: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referent’s Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Gender: ⁮[ ]  Male ⁮ [ ]  Female

Age: **\_\_\_\_\_\_\_** SSN: **\_\_\_\_\_\_\_\_\_\_** DOB: **\_\_\_\_\_\_\_\_\_\_**

Marital Status: [ ]  Single [ ]  Married [ ]  Divorced [ ] Widowed (Separated)

Medicaid #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Current place of residency: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of emergency, was there a TDO**: ⁮ [ ]  YES ⁮ [ ]  NO

**Referents presenting need:**

[ ]  Individualized training in acquiring basic living skills (i.e. managing symptoms)

[ ]  Assistance in maintaining medication management for prescribed psychotropic medications

[ ]  Assistance in adhering to psychiatric treatment plans

***Assistance in developing and appropriate use of:***

[ ]  Social skills/personal support system [ ]  Personal hygiene routines

[ ]  Food preparation [ ]  Money Management/Budgeting

NOTES (please cite specific issues client is experiencing):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does client meet MHSS criteria:** **Does referent have a mental health diagnosis?**:

* Psychotic disorder [ ]
* Major depressive disorder-recurrent, or [ ]
* Bipolar disorder I or II: [ ]
* If none are applicable, current diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the referent have a prior history of receiving mental health treatment in any of the following:**

Psychiatric Hospital [ ]  PACT or ICT services [ ]

Residential Treatment Facility [ ]  RTC-Level C placement [ ]

NR/R Crisis Stabilization Program [ ]  TDO evaluation (temporary detainment order) [ ]

**Has the referent had a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the assessment date?** [ ]  Yes [ ]  No

**Client’s Disposition:** [ ]  Admission to MHSS – assessment appointment confirmed

 [ ]  Pending status: \_\_\_ No Medicaid \_\_\_ Confirming Hospitalizations

 \_\_\_Confirming Medications

 [ ]  Referred to other services (Name of agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)