**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):

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**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)