**Assertive Community Treatment (ACT) / Mobile Treatment Team**

**Instructions**: Complete as much information as possible for the person being referred for services and fax directly to the ACT/Mobile Treatment program. Incomplete referrals will be considered but more comprehensive information will assist with determining eligibility.

**Name Date**

**Address Phone Number**

**Homeless**:

🗆 YES 🗆 NO

**If yes**: Where can the client be found, or where does he/she frequent?

**If no**: Select what best describes current living situation:

🗆 Halfway House/Group Home 🗆 Supervised Living 🗆 Independent Apartment 🗆 Living w/ Non-Relatives

🗆 Living with Relatives 🗆 Rents Own Room 🗆 COC/Shelter Plus Care 🗆Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**:

🗆 Medicaid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🗆 Medicare 🗆 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender Identity**:

🗆 Male 🗆 Female 🗆 Transgender Man/Transman 🗆 Transgender Woman/Transwoman

🗆 Genderqueer/Gender Nonconforming 🗆 Additional Identity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🗆 Declines to state

**Race**:

🗆 African American 🗆 Caucasian 🗆 Asian 🗆 American Indian/Alaskan Native

🗆 Asian 🗆 Native Hawaiian and Other Pacific Islander

**Ethnicity**:

🗆 Hispanic 🗆 Non-Hispanic

**Primary Language**:

🗆 English 🗆 Other (Specify, including ASL):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Veteran**:

🗆 YES 🗆 NO

**Traumatic Brain Injury (TBI)**:

🗆 YES 🗆 NO

**Emergency Contact / Special Instructions**

**Name Relationship**

**Address Phone Number**

**Reason for ACT Services Request**: Eligibility Criteria

1. **Is the individual 18 years old or over?**

2. **Does the consumer have a PMHS specialty mental health DSMV diagnosis included in the Priority Population, which is the cause of significant psychological, personal care and social impartment?**

3. **The impartments result in a t least one of the following**:

 a. A clear, current threat to the individual's ability to live in his/her customary setting, or the individual is homeless, and would meet the criteria for a higher level of care if ACT/mobile treatment services were not provided

 b. An emerging/impeding risk to self or others

 c. Inability to engage in traditional outpatient treatment

4. **Inability to form a therapeutic relationship on an ongoing basis as evidenced by one or more of the following**:

 a. Frequent use of emergency rooms for psychiatric reasons

 b. Psychiatric hospitalizations

 c. Arrest for reasons associated with the individual’s mental illness

5. **Has demonstrated significant functional impairments due to acute symptoms in at least one of the following**:

 a. Employment

 b. Self-care

 c. Socialization

 d. Practical daily living skills

 e. Substance use

6. **Resides in Baltimore City**:

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

🗆 YES 🗆 NO

**Diagnostic Evaluation**:

Behavioral Health:

Medical:

Social:

**Mental Health Status**:

Current Symptoms/Mental Health Status:

Current Suicidal Ideations/Homicidal Ideations and Aggressive Behaviors:

Suicidal Ideation/Homicidal Ideation History:

Approximate number of inpatient psychiatric admissions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the following for the most recent admissions:

Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most recent mental health provider name:

**Name Date of Treatment**

**Address**

**Phone Number Fax Number**

**SUBSTANCE USE**:

**Current Substance Use**: 🗆 YES 🗆 NO

**Substances Used**:

Name of drug Frequency Withdraw Symptoms Mode Date of last use

**Past Substance Use**: 🗆 YES 🗆 NO Approximate date last used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current/Past Substance Use Treatment** (including inpatient/outpatient, maintenance programs, etc.):

**Medical**:

**Medical Issues**

**Physical Limitations, if any**

**Allergies**

**Most Recent Primary Care Provider Phone Number**

**Date of last visit**

**All Medications:**

**Name Dose & Frequency**

**Name Dose & Frequency**

**Name Dose & Frequency**

**Name Dose & Frequency**

**Name Dose & Frequency**

**Name Dose & Frequency**

**Legal History:**

Any current legal concerns/status: 🗆 YES 🗆 NO 🗆 UNKNOWN. If yes, explain briefly:

**Community Support:**

Identify any support systems client may have (family, friends, community, etc.) and any programs that the client frequently visits. Please include any cultural issues to consider:

**Additional information pertinent to the referral:**

**Have you discussed a referral to Assertive Community Treatment with the client?** 🗆 YES 🗆 NO