PACT REFERRAL FORM

Hinds Behavioral Health Services

Case Name _____

Case Id# _____

Date _____

SS#:_____DOB _____

Address:_____Phone:_____

Age:_____ Medicaid: Yes_____No_____ Referral Source:_____

Admission Criteria

Psychiatric hospitalizations in the past 24 months (Please list hospital(s), admission & discharge dates, and reason(s) for hospitalization):

(Check all that Apply)

____Persistent or recurrent severe affective, psychotic or suicidal symptoms

____Co-existing substance abuse disorder greater than six months. Drug of choice:

____High risk or recent history of criminal justice involvement in the past 12 months

Arrest/release date & place

Probation?

Parole?

____Residing in substandard/unsafe housing, homeless, or imminent risk of becoming homeless OR residing in supportive housing but clinically assessed to live in a more independent living situation if intensive services are provided

____Inability to participate in traditional office-based services

____Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in community living

- ____ Maintaining personal hygiene
- ____Caring for personal business affairs
- ____Recognizing & avoiding common dangers
- ____Inability to maintain safe living situation
- ____Meeting nutritional needs
- ____Obtaining medical/legal/housing services
- ____Inability to maintain employment

Staff Member Taking Referral:_____ Date:_____

Comments:

Symptoms and Behavioral Challenges (risk of harm to self or others, etc)

History of Violent/Aggressive Behavior:

Current Living Situation:

Current Medications:

Diagnosis

Axis I:_____

Axis II:_____

Axis III:_____

Axis IV:_____

Axis V:_____

ICD10

Dx 1 _____

Dx 2 _____

Dx 3 _____

Staff Member Taking Referral:_____ Date:_____

Comments: