Assertive Community Treatment
Referral Form

Name:_____**DOB:**_____**SSN:**_____

Address/location:_____**Phone:**_____

Family/support name:_____ **Phone:**_____

Medicaid #_____

Admission Criteria:

A. Diagnoses:

☐Schizophrenia ☐Schizoaffective Disorder ☐Bipolar disorder
☐Major depressive disorder with psychosis ☐Unknown

B. Significant functional impairment in at least one of the following:

☐Consistent inability to perform practical daily tasks needed to function in the community, such as, personal hygiene, meeting nutritional needs, managing personal finances, obtaining medical, legal and housing services or recognizing and avoiding common dangers.
☐Persistent or recurrent failure to perform daily living tasks, except with significant support from others, such as family or friends.
☐Consistent inability to be employed at a self-sustaining level or to carry out homemaker role.
☐Inability to maintain a safe living situation.

C. At least one or more of the following which are indicators of continuous high-service needs:

☐Hospitalizations
- ☐Two or more psychiatric or substance abuse related hospitalizations in the past 12 months.
- ☐One psychiatric or substance abuse related hospitalization in excess of 10 days in the past 12 months.
- ☐Three or more psychiatric or substance abuse related emergency room visits in the past 12 months.

☐High risk or recent history of criminal justice involvement.
☐Risk of homelessness
- ☐Street dwelling homeless:
- ☐Residing in homeless shelter
- ☐Residing in substandard housing
- ☐At imminent risk of becoming homeless

☐Difficulty effectively engaging in and/or utilizing traditional office-based services.

Please attach supporting documentation if available including:

☐Psychiatric evaluation/psychosocial assessment

☐Medication records

☐Hospital records

Additional Comments:

Referral completed by:_____ Date:_____

Organization:_____

Contact number:_____ E-mail address: _____

Please submit to: TNACTReferrals@rhd.org

RHD DECISION

Date:

☐ Individual meets criteria and will be admitted to the ACT Team

☐Individual is not being admitted due to the following reason:

- ☐Not clinically appropriate
- ☐Does not meet criteria
- ☐Refused services
- ☐Unable to locate

Comments: