Mental Health &Addictions
Assertive Community Treatment Team (ACTT) Referral Form

Client Name:_____ Address:_____ _____ _____	Client aware of referral: ☐ Yes ☐ No Phone #:_____ Leave Message? _____ HCN:_____ Current Psychiatrist:
Date of Birth (DD/MONTH/YYY):	Referral Name:
Client's age (must be 18+):	Referral Phone #:
Gender: ☐ Male ☐ Female	Date of Referral (DD/MONTH/YYY):

Please provide the following information for the past *12 months*:

Diagnosis:_____
_____

- **Identify areas where the client currently experiences significant functional impairment:**

☐ Obtaining / managing medical, legal, & housing services	☐ Meeting nutritional requirements / meal management
☐ Household management	☐ Budgeting
☐ Medication management	☐ Maintaining personal hygiene
☐ Recognizing & avoiding common dangers / hazards to self & possessions	☐ Participating in social / leisure opportunities; social isolation
☐ Education	☐ Communication
☐ Employment	☐ Concentration
☐ Other :_____	

Or persistent or recurrent difficulty performing the aforementioned daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

- Housing Concerns in past 12 months (include sub-standard housing, evictions/risk of eviction, shelter use, homelessness):
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  _____
  _____
  _____

- Number of psychiatric admissions in the past 12 months (please include short stay admissions):
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  _____
  _____
  _____

- Number substance abuse/gambling related inpatient admissions in past 12 months, including Acute Care, Recovery Center, Treatment Centers:
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- Number ER/Psychiatric Assessment Unit (PAU) visits, Mobile Crisis Unit use in past 12 months:

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_____
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_____

- Long-term Psychiatric hospitalization(s) in past 12 months, i.e., 3+ months:

_____
_____
_____
_____

- Number Legal Involvement/Contacts in past 12 months (include visits by law enforcement not resulting in charges, conveyance by law enforcement to lock-up or ER, arrests, charges, incarcerations, and any juvenile history (if applicable):

_____
_____
_____
_____

- Housing Services Used in past 12 months (i.e., supervised living arrangements, assisted living, personal care homes):

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_____
_____
_____

- Describe history of Mental Health outpatient service referrals/use (include dates, agencies, frequency of use/contact, outcomes, etc.)

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_____
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_____

- Has a Client/Site Risk Assessment been completed? Please list identified risks:

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- Additional Information:

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