FAMILY PSYCHOLOGICAL
Together With Kids Count Inc
IMPROVING LIVES IN OUR COMMUNITY
BUTLER 724.287.1880 | CLARION 814.226.4913 | INDIANA 724.349.6320 | KITTANNING 724.543.1888

Blended Case Management Referral

I. IDENTIFYING INFORMATION			
Date of Referral		Consumer Name	
Date of Birth		Age	
Current Address		Phone	
MA #		Marital Status	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed
SSN		Veteran	☐ Yes ☐ No
History of Homelessness?	☐ Yes ☐ No	In School	☐ Yes ☐ No If yes, list grade:
For Children: Parent/Guardian		IEP	☐ Yes ☐ No

II. REFERRAL SOURCE			
Person Making Referral (Name & Title)		Phone	
Representing Agency			
Date &Time of Next Outpatient Appoint.			

III. DSM IV DIAGNOSIS			
Diagnosed by		Date	
Axis I			
Axis II			
Axis III			
Axis IV			
Axis V			

IV. SERVICE NEEDS THAT REQUIRE COORDINATION : Please Be As Specific As Possible

MH Treatment:

Housing/Living:

Education/Employment:

Support System:

Basis Activities of Daily Living

D&A Treatment::

Medical Treatment:

Name:_____ **MA#:**_____

V. SERVICE PROVIDERS INVOLVED WITH THIS CONSUMER					
Type of Service					
☐ CYF	☐ Partial Hosp.	☐ OP MH	☐ OP D/A	☐ Psych Rehab	☐ Mobile Medications
☐ Social Security		☐ Education	☐ LTSR	☐ OVR	☐ D/A CM
☐ Inpatient/ Out of Home placement			☐ Strength Based Treatment		☐ IOP
☐ FBMHS	☐ BHRS	☐ RTF	☐ WIC	☐ JPO	☐ Adult Probation
☐ Clozaril & Support Services		☐ Methadone	☐ Housing		
☐ Other _____		☐ Other _____		☐ Other _____	

VI. PREVIOUS PSYCHIATRIC HOSPITALIZATIONS	
Facility	Dates (From – To)

VII. ADULT TREATMENT HISTORY	
☐ Six or more days of inpatient mental health treatment in the past 12 months	☐ Met 302 standards in past 12 months
☐ At least three missed community mental health service appointments or documentation the individual has not maintained his/her medication regimen for a period of at least 30 days	☐ Two or more face-to-face with crisis intervention in past 12 months
☐ Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems	☐ History of State Hospitalization within past 12 months. Discharge Date:_____
☐ Adults who were receiving case management services as children	☐ **Adults** - GAF 60 and below

VIII. CHILD AND ADOLESCENT TREATMENT HISTORY	
☐ Six or more days of inpatient mental health treatment in the past 12 months	☐ Met 302 standards in past 12 months
☐ Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems	☐ Without case management services would result in out- of- home placement
☐ **Children/Adolescents** - GAF 70 or below	

NOTE: Please include a copy of a signed evaluation that will substantiate the DSM IV diagnosis.