

Name of participant: _____
Date of birth: _____
Prime number (if applicable): _____

Assertive Community Treatment (ACT) Universal Referral Form

Date form is sent: _____
Referring party name and title: _____
Referring party agency contact information: _____
Type of request:
 New referral: Clinical notes attached? Yes No. If no, why? _____
 Transfer. ACT Program Transferring from and contact: _____
Current location: _____ Participant phone number: _____
Address/anticipated address: _____
Anticipated county to reside: _____
Gender identity preferences: _____
Cultural identity: _____ If Tribal, what tribe: _____
Linguistic preferences: _____
Guardian primary contact: _____ Guardian phone number: _____
Home CCO/insurance type: _____
Primary mental health diagnosis: _____
Most recent clinical assessment: _____
Who completed assessment: _____
Aid and assist: Yes No Anticipated discharge date: _____

Note: per OAR 309-019-0245(1)(b), Individuals with a primary diagnosis of a substance use disorder, borderline personality disorder, autism spectrum or intellectual disabilities are not the intended population for ACT.

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1. Does the client exhibit significant functional impairments as demonstrated by at least one of the following conditions?
- Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (*e.g., caring for personal business affairs; obtaining medical, legal, or housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs, maintaining personal hygiene.*) Briefly describe:

Significant difficulty maintain consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (*e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities*). Briefly describe:

Significant difficulty maintaining a safe living situation (*repeated evictions or loss of housing*). Briefly describe:

2. Does the client have a secondary co-occurring disorder that also impacts their ability to function in the community?

Substance use disorder: Yes No. If yes, please list: _____

Other co-occurring disorder: Yes No. If yes, please list: _____

3. Client with one or more of the following indicators of continuous high service needs (*check all that apply*):

High use of acute psychiatric hospitals (Two or more admissions per year) or psychiatric emergency services.

Intractable (*e.g., persistent, or very recurrent*) severe major mental health symptoms (*affective psychotic, suicidal*).

Coexisting substance use disorder of significant duration (*greater than six months*).

High risk or recent history of criminal justice involvement (*e.g., arrest, incarceration*).

Significant difficulty meeting basic survival needs, residing in substandard housing, houselessness, or imminent risk becoming houseless.

Residing in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.

Difficulty effectively utilizing traditional office-based outpatient services.

Additional information

(Other programs involvement/referrals or any other identifying factors that will assist in transition)

ACT program (or SPOC) determination

Date referral received: _____

Accepted for next steps of review:

- Anticipated date of intake/screening evaluation: _____
- Waitlisted: Yes No

Pending (*list reason for selecting this*): _____

Denied (*list relevant OAR's*): _____

- If denied, please identify alternative recommendations of community-based services to be provided:

Signature of ACT Services Representative

(Whoever made final determination)

Date

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Adult Mental Health Program at languageaccess.info@odhsoha.oregon.gov or 1-844-882-7889 (voice). We accept all relay calls.