## Referral: Mental Health Skill Building

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|---|---|---|
| Client Name: | | Date: |
| Address: | | |
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|---|---|---|---|
| Phone Number | (H): | (Cell): | (W): |
| Date of Birth: | | SSN: | |
| Sex: | | Medicaid Number: | |
| Is client QMB? Yes No | Spend Down Amount: | | |
| | | Medicare Number: | |
| Name of MCO: | | Managed Care Company ID Number: | |
| Name of MCO Care Coordinator: | | | |

| **Describe current strengths, needs and level of functioning in following domains.** **(*Fields will expand when you type in boxes)** | | | | | | |
|---|---|---|---|---|---|---|
| **Personal Hygiene and Grooming** | | | | | | |
| **Menu Planning and Grocery Shopping** | | | | | | |
| **Prepare Healthy Snacks and Meals** | | | | | | |
| **Cleaning Apartment/Housekeeping** | | | | | | |
| **Ability to structure daily routine** | | | | | | |
| **Budgeting Money** | | | | | | |
| **Attending to Physical Health** | | | | | | |
| **Scheduling and Keeping Health Care Appointments** | | | | | | |
| **Using Public Transportation** | | | | | | |
| **Following a Lease Agreement/Negotiating with Landlord** | | | | | | |
| **Interpersonal/social Skills** | | | | | | |

| Symptom Management | None | Poor | Fair | Good | Excellent | Comment(s) |
|---|---|---|---|---|---|---|
| **Safety Skills** | | | | | | |
| **Taking Medications as Prescribed – Medication Management** | | | | | | |
| **Recognizing Stressors that Increase Symptoms** | | | | | | |
| **Problem-Solving Skills** | | | | | | |
| **Coping Skills** | | | | | | |

| | Yes | No |
|---|---|---|
| Current alcohol/Substance Use<br>If yes, identify substance of choice: | | |
| Past History of Alcohol and/or Substance Use | | |
| Current Suicidal Thoughts/Behavior<br>If yes, please provide information to determine level of risk and what helps client be safe.<br><br>Date of last suicide attempt: | | |
| Past History of Suicidal Thoughts/Behavior<br>Number of attempts: | | |
| Current Aggressive, Homicidal or Threatening Behavior<br>If yes, please describe: | | |
| Past History of Aggressive, Homicidal or Threatening Behavior<br>If yes, please describe: | | |

| | Yes | No |
|---|---|---|
| Is client on probation? | | |
| Is client parole? | | |
| Is client NGRI? If yes, please specify charge and attach current release agreement. | | |

| *One item must be checked "yes" to be funded by Medicaid for Mental Health Skill Building | Yes | No | Date(s): | Location |
|---|---|---|---|---|
| Has client had a psychiatric hospitalization? | | | | |
| Has client been evaluated for a temporary detention order (TDO)? | | | | |
| Has client been served by a PACT/ACT team? | | | | |
| Has client received services from Intensive Community Treatment? | | | | |
| Has client been in a crisis stabilization program? | | | | |

| DSM Diagnosis Code | DSM- IV Name | Date: |
|---|---|---|
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*If the client does not have a diagnosis such as a Psychotic Disorder, Bipolar I or II and/or Major Depression, Recurrent episodes, or if the client has any diagnosis that is "Not Otherwise Specified" (NOS) Disorder; complete the following section for Medicaid-funded Mental Health Skill Building.

**Please indicate Yes or No to the following questions:**

| | Yes | No |
|---|---|---|
| 1. Is the Axis I disorder(s) a serious mental illness? | | |
| 2. Does the disorder(s) result in severe, recurrent disability? | | |
| 3. Does the disorder(s) result in functional limitations in major life activities? | | |
| 4. Does the individual require individualized skills teaching in order to maintain independent living in the community? | | |

| **Signature of Physician/Nurse Practitioner and/or Psychiatrist:** (*must be signed by the treating prescriber or practitioner) | **Date:** |
|---|---|
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| Prescribed Medication(s) | Dosage | Frequency | Comments |
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List of other Medication(s), including over the counter medication(s) the client is taking:

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| | Yes | No |
|---|---|---|
| 1. Does the client have any allergies to medication(s)? If yes, please list medication(s) the client should not take: | | |
| 2. Does the client have a history of not taking medication(s) as prescribed? | | |

| List Most Effective Medication(s) | List Least Effective Medication(s) |
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***Required clinical documentation may be attached from the Provider's Electronic Health Record if the above information is covered.**

| **Signature of Referral Source:** | **Date:** |
|---|---|
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**Form Completed by:**

| | | |
|---|---|---|
| Staff Name: | | Date: |
| Address: | | |
| | | |
| Phone Number: | | |
| Email: | | |

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