**Referral: Mental Health Skill Building**

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| --- | --- | --- | --- | --- | --- | --- |
| Client Name: |  | | | | | Date: |
| Address: |  | | | | | |
|  |  | | | | | |
|  |  | | | | | |
| Phone Number: | (H): | | | (C): | | |
| Date of Birth: |  | | | SSN: | | |
| Sex: |  | Gender Preference: | | Pronouns: | | |
| Medicaid Number: | | | Medicare Number: | | | |
| Name of MCO: | | | MCO ID Number: | | | |
| Name of MCO Care Coordinator: | | | | | Phone Number: | |

*\*Please note we cannot provide services to individuals with QMB Medicaid*

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| --- | --- | --- | --- | --- | --- | --- |
| Please describe current strengths, needs and level of functioning in following skills. | | | | | | |
|  | None | Poor | Fair | Good | Excellent | Comment(s) |
| 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) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 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 |  |  |  |  |  |  |

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| --- | --- | --- |
| Substance Use/Safety Risk | Yes | No |
| Current alcohol/Substance Use: |  |  |
| If yes, please identify substance of choice: |
| Past History of Alcohol and/or Substance Use: |  |  |
| Current Suicidal Thoughts/Behavior:  If yes, please provide information to determine level of risk and attach safety plan: |  |  |
| History of Suicidal Thoughts/Behavior:  If yes, please indicate date of last suicide attempt and number of attempts: |  |  |
| Current Aggressive, Homicidal or Threatening Behavior  If yes, please describe and attach safety plan: |  |  |
| History of Aggressive, Homicidal or Threatening Behavior  If yes, please describe: |  |  |
| Is client on probation? |  |  |
| Is client parole? |  |  |
| Is client NGRI? If yes, please specify charge and attach current release agreement |  |  |

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| --- | --- | --- | --- | --- |
| Hospitalization/Crisis Stabilization History | 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? |  |  |  |  |

\**At least one item above* ***must*** *be checked “yes” to be funded by Medicaid for Mental Health Skill Building*

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| --- | --- |
| **DSM Diagnosis Code** | **DSM- V Name** |
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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, please contact us prior to submitting the referral as there is an additional form that will need to be completed.*

|  |  |  |
| --- | --- | --- |
| **Prescribed Medications** | **Yes** | **No** |
| Is the client prescribed any medications?  If yes, please attach list of current medications or list below |  |  |
| Does the client have any allergies to medication(s)?  If yes, please list medication(s) the client should not take: |  |  |
| Does the client have a history of not taking medication(s) as prescribed?  If yes, please describe: |  |  |

*\*If the individual is not prescribed medications, clinical documentation of contraindication from the Provider’s Electronic Health Record must be attached.*

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| --- | --- | --- | --- |
| Prescribed Medication(s) | Dosage | Frequency | Comments |
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| --- | --- |
| **Signature of Referral Source:** | **Date:** |
|  |  |

*\*Please include a completed release of information form so that we may contact you for additional information regarding the referral if needed*

**Form Completed by:**

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

**Mail/Fax/Secure Email to:**

|  |  |
| --- | --- |
|  | |
| Sarah M. Egresi, MSW, LCSW, LMHP  Director of Community Support Services  10455 White Granite Dr., Suite 400  Oakton, VA 22124  Phone: (703) 622-7566  Fax: (703) 448-3723  Email: segresi@hopelinkbh.org | Laura Fonner, MA, LPC, LMHP  Chief Clinical Officer  10455 White Granite Dr., Suite 400  Oakton, VA 22124  Phone: (703) 622-6109  Fax: (703) 448-3723  Email: lfonner@hopelinkbh.org |