North Sound PACT Referral Form

(Program for Assertive Community Treatment)

North Sound PACT is a community-based team that provides intensive community based treatment with adults who have severe, and persistent co-occurring mental health disorders. Our team provides wrap around care that includes: Psychiatric Provider, Registered Nurse, Mental Health Professional, Co-Occurring Disorders Specialist, Case Management specializing in vocational and education supports, psychiatric rehabilitation, and peer support. To qualify for the North Sound PACT program, the client must reside in Whatcom County and have:

- *Primary diagnoses of schizophrenia or other psychotic disorder such as Bipolar disorder.*
- *Major functional impairment such as being unable to live independently, difficulties maintaining ADLs and /or meeting criteria for grave disability.*
- *Problems using traditional office based mental health services*

AND at least two one of the following:

- *Two psychiatric hospitalizations in the past 12 months (depending on where they were hospitalized)*
- *Symptoms are persistent and recurrent*
- *Recent history of criminal justice involvement (frequent contact with law enforcement, incarcerations, and/or supervision)*
- *Homeless or at imminent risk of homelessness, or residing in unsafe/unstable housing*
- *A co-occurring disorder has been present for at least 6 months*
- *Living in an inpatient facility (Telecare, Western State Hospital, SSBH.), but could live more independently if intensive services were provided.*

Note: PACT does not work well for clients where the primary diagnosis is a personality disorder, substance use, traumatic brain injury, or developmental disability.

Based on the information above, if you feel the client in question is a fit for PACT services, please fax completed form PACT Team at (360) 306-8374.

North Sound Program for Assertive Community Treatment (PACT)
Referral Request Form

Please Fax the following information with the referral form, if available:**

☐ Mental Health Assessment

☐ List of current medications (MAR if available, but not necessary)

☐ Current Chart notes, including psychiatric, for the past month

☐ Release of information for Lifeline Connections (must be included in referral)

Return completed referral to: Julie Grendon, Attention: "NS PACT Referral."
(for LLC employees, send via internal email, for outside agencies,
please fax to (360) 306-8374)
For any questions about the referral form or to consult about whether a client is appropriate, prior to completing this form, feel free to contact the Community Based Services Director, Julie Grendon (360) 397-8246 ext. 33108

Please note that if this referral is coming from an agency that provides mental health services the referral will not be considered until all needed information is provided.

Referral Information

<table>
<tr><td>Referral Date:_____</td><td>Referring Individual:_____</td></tr>
<tr><td rowspan="3">Have PACT Services been discussed with the client? ☐Yes ☐ No
If so, how open are they to the program?_____

If not, why?_____</td><td>Agency/Job Title:_____</td></tr>
<tr><td>Phone number/Fax:_____</td></tr>
<tr><td>Email:_____</td></tr>
</table>

<table>
<tr><td>Client Name:_____</td><td>Client DOB (must be over 18):_____</td></tr>
<tr><td>Client Address:_____</td><td>Client phone number:_____</td></tr>
<tr><td colspan="2">What kind of insurance does the client have?
☐ Medicaid ☐ Medicare ☐ Spenddown (Amount $_______) ☐ No Insurance ☐ Private Insurance (Type: ____________)</td></tr>
</table>

Guardian (if applicable, provide copy court order): _____
Payee: _____
Mental Health or Medical Advance Directive (Provide copy):☐ Yes ☐ No

Clinical Information. *Eligibility: Please note, to be eligible for PACT an individual must have a primary diagnosis of a severe and persistent mental illness. Eligible diagnoses include schizophrenia, schizoaffective disorder, other psychotic disorders, and mood disorders (bipolar/depression) with psychotic features, with demonstrated need for intensive support.*

Does the individual being referred have an existing mental health diagnosis? ☐ Yes ☐ No Please list any known diagnoses:
Diagnosis 1:_____
Diagnosis 2:_____
Diagnosis 3:_____

Does the individual being referred have a substance use disorder diagnosis? ☐ Yes ☐ No
If yes, 1) What substances do they use: _____ 2) What stage of recovery (actively using, in recovery) are they in? (*PACT provides services for all stages of recovery*): _____
Does the client have a personality disorder; either documented or suspected? (*PACT cannot accept those with a personality disorder due to the program not being conducive to their recovery*): ☐Yes ☐ No
Does the client have a developmental disability? ☐Yes ☐ No If yes, what disability: _____

Does the client have a PCP? ☐ Yes ☐ No If yes, name of PCP: _____
Medical issues patient has currently and/or in the past: _____

Service History: *Eligibility: Continuous high-service needs due to mental illness demonstrated by the following: (please check all that apply and explain in narrative below under More Info)*

☐ High use of acute psychiatric hospitals (i.e. 2 or more admissions per year or psychiatric emergency services.)

☐ Intractable (i.e. persistent of very recurrent) and severe symptoms (i.e. psychotic, manic, suicidal). Identify major symptoms:

☐ Co-Occurring Substance Use disorder of significant duration (longer than 6 months).
Client's Drug of choice:
Duration of use:

☐ Significant difficulty meeting basic survival needs or residing in substandard housing

☐ At risk of becoming homeless

☐ Is individual chronically homeless?
What are barriers to obtaining housing?
Number of episodes of homelessness in the last 5 years and when:

☐ Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided.

☐ Difficulty effectively utilizing traditional office-based outpatient services or other less intensive community based programs (i.e. consumer fails to progress, drops out of services)

Is the individual already receiving services for mental health? ☐ Yes ☐ No If yes, where? _____		
Where has the individual received mental health/substance use treatment in the past?:_____		
Program/Agency	Estimated Dates	Reason for treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalization History: *Eligibility: Two psychiatric hospitalizations in the past 12 months. Not meeting these criteria is not an immediate disqualifier*

Hospital Name	Admitting Reason	ITA? (Y or N)	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Incarceration History: *Eligibility: High risk or recent history of criminal justice involvement (frequent contact with law enforcement, incarcerations, and/or supervision)*

All known incarcerations, arrests or other law enforcement contacts, with details as available:

Correctional Facility	Charges	Arrests/Contact with Law Enforcement	Approx. dates
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____

Functional Impairments: *Eligibility: The individual experiences significant functional impairments due to mental illness as demonstrated by the following conditions*

☐ Significant difficulty maintaining consistent employment at a self-sustaining level
☐ Significant difficulty with consistently performing the range of practical daily living skills required for basic adult functioning in the community (i.e. having and following through with medical care, recognizing and avoiding common dangers or hazards to self and possessions, meeting nutritional needs, maintaining personal hygiene)
☐ Persistent or recurrent difficulties performing daily living tasks except with significant support or assistance from others such as friends, family or relatives.
☐ Significant difficulty maintaining a safe living situation (i.e. repeatedly forgetting to turn stove burners off, consistent unsanitary conditions due to uncollected garbage, food scraps)
☐ Other significant difficulties: _____

In general, services that NS PACT provides are the following (please check those that you and your client would like to be included in a treatment plan)	**Client Requests**	**Referral Source Requests**
Assistance with medical/dental care	☐	☐
Assistance with medication management	☐	☐
Assistance with daily living skills (i.e. shopping, hygiene, cooking, etc.)	☐	☐
Assistance with money management	☐	☐
Assistance with employment/education	☐	☐
Assistance with mental health therapy/counseling	☐	☐
Assistance with cultural differences	☐	☐
Assistance with social skills	☐	☐
Assistance with transportation to medical appointments and/or grocery shopping	☐	☐
Assistance with reducing/stopping drugs/alcohol/tobacco use	☐	☐
Assistance with leisure activities (hobbies/skills)	☐	☐
Assistance connecting/reuniting with family/supports	☐	☐

NS PACT STAFF USE ONLY

Does Client meet the minimum qualification of the Program? If not, why? ______

Can PACT provide services needed to meet patient needs? ______

If not, what referrals were provided: ______

Is the individual willing to meet with a PACT case manager or MHP for an intake assessment? ☐ Yes ☐ No

Date of Assessment: ______