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Assertive Community Treatment (ACT) Program
Provider Referral Form

When making referrals please fill out this form completely and email to our ACT Team coordinator at lfitts@questreno.com

Date of Referral: _____

Client Name: _____ Phone Number: _____

D.O.B: _____ Age:(must be 18+) _____ Sex: _____ Marital Status: _____

Home Address: _____City: _____

Current Location if other than home: _____

Lives with: _____ Primary Language: _____

Primary Family/Emergency Contact: _____Phone#: _____

Insurance: _____

ACT requires one of the following diagnosis. Please check which is applicable to the referred individual. ___Major Depression ___Schizophrenia ___Schizoaffective Disorder ___Bipolar Disorder Other noted diagnosis:	ACT cannot serve people who have one of the following primary diagnosis. DO NOT REFER Unless the presence of the behaviors or functional limitations experienced by the person are correlated to primary mental health disorder. Please check applicable diagnosis: ___Borderline Personality Disorder ___Anti-Social Personality ___Substance Use Disorder ___Traumatic Brain Injury ___Developmental disability ___Autism/Asperger's

Referral Information

Name of person & agency completing this form: _____

Relationship to client: _____ Phone#: _____

Reason for referral at this time (select all that apply)

___Not currently receiving mental health care

___Has had two or more admissions in a psychiatric/acute hospital in the last 6 months

___Frequent use of emergency room/ law enforcement services in the last 6 months.

___Difficulty in treatment adherence (e.g. keeping appointments or medication adherence).

___Unstable housing or facing imminent risk of homelessness.

___Has failed other traditional office-based outpatient services on their own.

Is the person interested in our Assertive Community Treatment program? Y___N__

If No, Why? _____

Is the family/support system interested? _____

If No, Why? _____

Current providers

Primary care doctor: _____

Psychiatrist/Therapist: _____

Current Psychiatrist/Therapist approves ACT referral? Y___N___

If Not, Why? _____

Is the client willing to switch to the ACT Team Provider? Y__ N__ (if not, cannot do ACT)

Does the client have any physical disabilities? Y___ N___ If yes please describe:

_____

Does the client have a history of substance abuse Y___ N___ If yes, describe the types of substance abused (e.g. alcohol, marijuana, crack/cocaine, prescription meds, etc. Is the client currently abusing substances? Is the client involved in any type of substance abuse treatment program?

_____

_____

_____

_____