



# DEPARTMENT OF HEALTH ADULT MENTAL HEALTH DIVISION REFERRAL FORM



**1. AGENCY REFERRING TO**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax No.: \_\_\_\_\_

**2. SERVICE REFERRING TO:**

**3. REFERRING AGENCY**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax No.: \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**4. CONSUMER DEMOGRAPHIC INFORMATION**

Name: \_\_\_\_\_ AMHD Ref. No.: \_\_\_\_\_

Gender:  Male  Female Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Type of Current Housing (i.e., 24 HR group home, E-ARCH, homeless, etc.): \_\_\_\_\_

Address: \_\_\_\_\_ Home Ph. No.: \_\_\_\_\_

*If homeless, indicate where the consumer can be found* \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Ph. No.: \_\_\_\_\_

**5. LEGAL GUARDIAN (if applicable)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**6. DIAGNOSIS**

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

**7. ELIGIBILITY**

The consumer has been determined eligible for AMHD services:  Yes  No

**8. FORENSICS**

Legal Status:  Conditional Release  Other (specify): \_\_\_\_\_

*Include a copy of the current conditional release or other current orders, if applicable.*

Court Date (if applicable): \_\_\_\_\_

Forensic Coordinator Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Parole/Probation Officer Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**9. HOSPITALIZED CONSUMERS (if applicable)**

Name of Hospital: \_\_\_\_\_

Discharge Meeting Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**10. HEALTH INSURANCE**

Name of Health Insurance Company: \_\_\_\_\_ Insurance Card No.: \_\_\_\_\_  
*(i.e., HMSA, Kaiser, etc.)*

**11. INCOME**

Monthly Income: \$ \_\_\_\_\_

Source of Income (i.e., work, SSI, SSDI, DHS, etc.): \_\_\_\_\_

Other Assets (i.e., savings, etc): \_\_\_\_\_

**12. PSYCHIATRIST**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Fax No.: \_\_\_\_\_

**13. PRIMARY CARE PHYSICIAN (PCP)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Fax No.: \_\_\_\_\_

**14. CASE MANAGEMENT (CM) / ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM INFORMATION**

Agency Name: \_\_\_\_\_

CM/ACT Team Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

CM/ACT Team Address: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

**15. HOUSING**

Is housing needed?  Yes  No

Does the consumer have a Sec. 8 rental subsidy?  Yes  No

If referring for housing, indicate what level:  
*check only one (1) level*

24 Hour Group Home  
 8-16 Hour Group Home  
 Semi-Independent Group Home  
 Support Housing  
 Shelter Plus Care

If referring for housing, does the consumer require an accessible home or reasonable accommodation?  Yes  No

If yes, please describe what the consumer needs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**16. CITIZENSHIP**

Citizenship Status:  US  Other (specify): \_\_\_\_\_  Unknown

**17. TO BE COMPLETED FOR REFERRALS TO THE KALIHI PALAMA COMMUNITY FITNESS RESTORATION PROGRAM (KFIT)**

a. Current legal charges: \_\_\_\_\_

b. Legal Status (*check the status that applies*):  704-404  
 704-406  
 Other, specify: \_\_\_\_\_

c. Order to Treat:  Yes  No

d. Advance MH Directive:  Yes  No

e. History of Violence:  Yes  No

If yes, date of last/most recent physically aggressive, assaultive behavior: \_\_\_\_\_

If yes, date of last/most recent threatening behavior: \_\_\_\_\_

f. Risk of Suicide: Previous suicide attempt:  Yes  No  
If yes, date of last/most recent suicide attempt: \_\_\_\_\_  
Suicidal ideation:  Yes  No

g. Elopement Risk: Previous AWOL/AWA:  Yes  No  
If yes, date of last/most recent episode of AWOL/AWA: \_\_\_\_\_

h. Current or previous participation in fitness classes:  Yes  No

**18. INTERPRETER SERVICES**

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Does the consumer need an interpreter?  Yes  No

If yes, what language: \_\_\_\_\_

**19. REP PAYEE SERVICES**

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Does the consumer have a Rep Payee?  Yes  No

If yes, name of Rep Payee: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**20. OTHER CURRENT SERVICES**

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Indicate any services the consumer is currently utilizing:  Peer Coach  
 Respite  
 CRF - amount owed: \$ \_\_\_\_\_  
 CBI (includes 1:1 wrap)  
 Clubhouse  
 DVR

**21. PLEASE INCLUDE THE FOLLOWING DOCUMENTS:**

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- Consent to release information
- Master Recovery Plan (current)
- Most recent psychiatric evaluation with multiaxial diagnosis which is signed and dated
- Medical Problem List (include proof of PPD)
- Conditional Release or other Current Court Order (if applicable)
- HCR 20 (if applicable)
- Homeless certification (if referring for housing and if applicable)
- Copy of the order naming the guardian. (if #5 applies)

*Complete #22 only if you are referring to a service listed in a, b, c, d or e below. If the service you are referring to is not listed in #22, go to #23.*

**22. PLEASE INCLUDE THE DOCUMENTS FOR THE FOLLOWING SERVICES, IF AVAILABLE.**

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*Please note: This is in addition to the documents required in #21*

- a. Specialized Residential Treatment, Day Treatment, Intensive Outpatient Hospital, E-ARCH:
- Nursing Assessment (most recent)
  - Psychosocial Assessment
  - Risk Assessment
  - LOCUS (most recent)
  - Psychological Testing
  - Substance Abuse Assessment
  - Medication Sheet
  - Medical History and Physical (completed within one year of referral date and includes Rubella Titer/proof of immunizations, PPD)
  - Narrative update that includes presenting problem, precipitating events and justification for the service
  - Special diet requirements
  - Dental needs
  - Required for referrals to Specialized Residential Treatment: What is the current discharge plan upon completion of the program.

b. Hale Imua

- Nursing Assessment (most recent)
- Psychosocial Assessment
- Risk Assessment
- Psychological Testing
- Substance Abuse Assessment
- Medication Sheet
- Medical History and Physical (completed within one year of referral date and includes Rubella Titer/proof of immunizations, PPD)
- Special diet requirements
- Dental needs
- LOCUS (most recent)

c. KFIT

- Current psychiatric routine medications (name, strength/dosage, route, schedule)
- Current PRN medications. Include information on when the last PRN dosage was given.
- Add any medications being taken for medical problems listed on the medical problem list in #21.
- LOCUS (most recent)

d. ACT, CBCM, and Outpatient Treatment

- Nursing Assessment (most recent)
- Psychosocial Assessment
- Risk Assessment
- LOCUS (most recent)
- Psychological Testing
- Substance Abuse Assessment
- Medication Sheet
- Medical History and Physical (most current)
- Dental needs

e. PSR

- Nursing Assessment (most recent)
- Psychosocial Assessment
- Risk Assessment
- LOCUS (most recent)
- Substance Abuse Assessment
- Medication Sheet
- Medical History and Physical (completed within one year of referral date and includes Rubella Titer/proof of immunizations, PPD)
- Narrative update that includes presenting problem, precipitating events and justification for the service

23. REFERRAL FORM COMPLETED BY:

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

Date: \_\_\_\_\_

24. To be completed by the program receiving the referral.

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**PROVIDER DECISION FORM**

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TO: \_\_\_\_\_ FROM: \_\_\_\_\_  
*Referring Agency* *Provider and Type of Service*

CONSUMER NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AMHD REF#: \_\_\_\_\_

Date Referral Received: \_\_\_\_\_

Date Decision Rendered:  Accepted  Denied

Service Referred to (POS Provider): \_\_\_\_\_

**If consumer was denied for this service, please complete the rest of this form**

Current Diagnosis: Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

**Reason for Denial of Referral:**

- Consumer refused service
- Does not meet criteria for this service (Please provide explanation):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consumer may be accepted in the future under the following circumstances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

It is recommended that this consumer pursue alternative placement/treatment with another provider or at another level such as:

\_\_\_\_\_  
\_\_\_\_\_

Medical/Clinical Director Review: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature Date: \_\_\_\_\_

Administrative Executive Review: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature Date: \_\_\_\_\_