York/Adams Health Choices
Request for Diversion Meeting
Referral for EAC Consideration
(Revised 4-6-2016)

Demographic, Identifying and Contact Information:

(All the following information is required to activate a referral) Date_____

Client Name: _____ DOB: _____

MA ID#: _____ SS#: _____

Current Address: _____

Current Phone #'s: _____

Guardian Name: _____ Guardian Phone #: _____

Guardian Address: _____

BSU Case Manager: Name: _____ Phone #: _____

Facility making the referral? _____ Phone #: _____

Contact Name: _____ Position: _____

Email: _____

Referral discussed with consumer, guardian and/or family? _____

Member Response: _____

Please complete the following referral information as thoroughly as possible.

Current Symptoms:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Diagnosis (ICD 10)

Behavioral Health: _____

_____

_____

Co-morbid Physical Health issues and Psychosocial Stressors:

_____

_____

Indicators of Continuous High Service Needs:

A. List Hospitalizations for mental health and substance abuse treatment in the last 12 months:

Hospitalizations	Date of Hospitalization
1.	
2.	
3.	
4.	
5.	

B. List Incarcerations/Emergency Encounters/ in the last 12 months:

Facility/Agency	Date(s) of Encounter
1.	
2.	
3.	
4.	
5.	

C. List the current services the consumer is involved with or has been referred to in the last 12 months, including case management:

Type of service	# of contacts/week	Date Last Used	Outcome
1.			
2.			
3.			
4.			
5.			

D. List Substances Abused/Dependent:

Type	Frequency	Date Last Used
1.		
2.		
3.		
4.		
5.		

E. History of life threatening suicide attempts/life threatening self-harm within past two (2) years.

List Specific Behaviors:

Method	Date	Disposition
1.		

2. _____
3. _____
4. _____

F. History of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to other within last 2 years (ex. Assault, rape, arson)

	Type of Impulsive/Acting Out Behavior	Type of Assault/Anger	Disposition
1.			
2.			
3.			
4.			

Potential Discharge plan/Resource:

_____

_____

_____

Indicators of Consumer's Strengths and Supports

A. Identify consumer's support system, including family, friends, social, community

	List Supports and Relationship	Frequency of Contact
1.		
2.		
3.		
4.		

B. Identify Member Strengths:

1. _____
2. _____
3. _____
4. _____

Medical Conditions and Activities of Daily Living:

Medical Conditions:

1._____
2. _____
3. _____
4. _____
5. _____

Activities of Daily Living: Check all that apply

____Blind _____Hearing Impaired _____ Language Barrier ____ Independent with ADL's

____ ADL Dependent Explain_____

Current Medications Name Dose Frequency Reason

1. _____
2. _____
3. _____
4. _____
5. _____

Medication concern related to insurance/prescription coverage: _____

_____

_____

Demographic information:

Source of income: _____ **Rep Payee:** _____

Primary Care Physician: _____

_____

_____

Legal Issues: _____

_____

_____

Probation: _____

Jail time served: _____

Current commitment type: _____

Expiration date: _____

EMERGENCY CONTACT (must have one): _____

_____

_____

_____

Additional Information: _____

_____

_____

_____

_____.

Team Meeting Date_____

Team member	Representing:

Discussion/Outcome:_____

_____

_____

_____

_____

_____

_____

Actions Needed: _____

_____

_____

_____

_____