

York/Adams Health Choices
Request for Diversion Meeting
Referral for EAC Consideration
(revised 1-26-12)

Demographic, Identifying and Contact Information:

(All the following information is required to activate a referral) Date _____
Individual's 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 _____
Referral discussed with consumer, guardian and/or family? _____
Member Response: _____

Current Symptoms:

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

Current Diagnosis

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V Current _____ Past Year _____

Please note: If individual is struggling with any medical conditions (including eating disorders), please provide details under the medical condition section of this document.

Indicators of Continuous High Service Needs:

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

<u>Hospitalizations</u>	<u>Date of Hospitalization</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

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

<u>Facility/Agency</u>	<u>Date(s) of Encounter</u>
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:

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

D. List Substances Abused/Dependent:

<u>Type</u>	<u>Frequency</u>	<u>Date Last Used</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

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

List Specific Behaviors:

<u>Method</u>	<u>Date</u>	<u>Disposition</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Does the consumer have any relative that has a history of suicide attempt or suicide? If so, how are they related and how did it occur?

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)

<u>Type of Impulsive/Acting Out Behavior</u>	<u>Type of Assault/Anger</u>	<u>Disposition</u>
1. _____		
2. _____		
3. _____		
4. _____		

Has the consumer voiced any threats to hurt another person in the current hospitalization? Yes No
If Yes, please explain:

Pervious to the last 12 months has the consumer been convicted of a violent crime at any time in their life? Yes No If Yes, please explain:

Has there ever been any arrest for a crime and or violent behavior? Yes No If Yes, please explain:

Has the consumer ever had any issues with violence at a previous residential setting? Yes No If Yes, please explain:

Has the consumer ever been a victim of violence? If so what were the circumstances? Yes No If Yes, please explain:

Does the consumer have a history of physical, sexual, and or emotional trauma? Yes No If Yes, please explain:

Has the consumer been a witness of any sexual, physical, and emotional trauma? Yes No If Yes, please explain:.

How has the consumer coped with the history of trauma (both adaptive and maladaptive ways)

Potential Discharge plan/Resource (Please include any steps completed to date) _____

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. _____

Additional details regarding medical conditions/current plan addressing these conditions: _____

Activities of Daily Living: (Check all that apply)

____ Visual impairments ____ Hearing Impairments ____ Language Barrier
____ Independent with ADL's ____ ADL Dependent ____ Eating disorders

(If checked, explain) _____

Sleeping Patterns: (Please include average hours of sleep and how severe is the sleep disturbance, and any relationship to substance use or medication side effects) _____

Eating Patterns: (Please include average amount of meals daily and how severe appetite affected, and any relationship to substance use or medication side effects) _____

Has the individual has ever required IV's or an eating tube while being treated for an eating disorder?

Yes No If Yes, please when: _____

If applicable, please check: weight loss weight gain

Within (check one) _____ days _____ weeks _____ months

Current Medications Name	Dose	Frequency	Reason
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

Are all of the current medications prescribed on the individual's medication formulary? Yes No
 If no, which medications and any current plan to ensure individuals ability to obtain medications? _____

Additional Information: _____

Team Diversion Date _____

Team member	Representing:

Discussion/Outcome: _____

Actions Needed: _____

Was an NHS Human Service RN or MD present during Diversion Meeting Yes No
 If no, an RN or MD will be notified and review prior to acceptance/admission

Referral Form reviewed by: _____ Date: _____
 Signature (include credentials)

Comments: _____
