ADAMHS BOARD OF CUYAHOGA COUNTY
ALCOHOL, DRUG ADDICTION & MENTAL HEALTH SERVICES

PLEASE PRINT OR TYPE

ACT REFERRAL

Date:	Referring Agency:	Date of Admission to Agency:

Client Name:	Date of Birth:	SHARES No.	UCI No.	SS No.

Is client a legal resident of Cuyahoga County? Yes ☐ No ☐

Diagnosis:

Axis I:

Axis II:

Axis III:

Axis IV:

Is the client dually diagnosed (mentally ill/developmentally disabled, substance use disorder)? Yes ☐ or No ☐

If yes, please indicate:

Client's psychiatric hospitalization history during the *past 3 years*. (Please complete this section to the best of your ability.)

Hospital	Month/Year	Length of Stay	Reason for Admission

Persons who do not have repeated hospitalizations but are considered difficult to treat, generally non-responsive to treatment, and at high risk for hospitalization will also be considered. If the client meets this criteria, please describe:

Are there cultural issues which need to be considered when assigning this person to an ACT Team?

Primary language client speaks:
Describe the client's present living situation?
County of current living situation:
Expected date of discharge from current living situation:
Does the client have any physical disabilities? Yes☐ or No☐ If yes, describe:
Does the client have a history of substance use? Yes☐ or No☐ If yes, describe the types of substances used e.g. alcohol, marijuana, crack/cocaine, prescription meds, etc. Is the client currently using substances? Is the client involved in any type of substance use treatment program?
Does the client have a forensic status, i.e. has the client been found NGRI (not guilty by reason of insanity) or ISTU (incompetent to stand trial, unrestorable)? Is the client involved in the MDO (mentally disordered offender) program? If forensic, please specify including client's legal code number:
The ACT Model was designed for those clients in which traditional services has been unsuccessful in preventing or

reducing repeated hospitalizations, homelessness, and remaining stable in the community. Please give a detailed description of interventions that have been used to engage client in traditional CSP and outcome of the interventions.
Rationale for referral to an ACT Team:
Is the client agreeable to ACT services?
Current Medications: **Other:**

Name and Title of Person Completing this Form:	**Telephone Number:**
Name and Title of Authorizing Supervisor:	**Telephone Number:**
Print, mail or fax completed referrals to: **Maggie Tolbert** **Utilization Review Specialist** **ADAMHS Board of Cuyahoga County** **2012 West 25th Street 6th Floor** **Cleveland, Ohio 44113-3199** **FAX: 216-241-0805**	**ADAMHSCC USE ONLY:** **Date Sent: _____/_____/_____** **Agency:_____** **Date of Acceptance:_____/_____/_____**

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