COMPASS Health

PACT REFERRAL

Client Name/ID/DOB *(or affix label)*	Date: _____	Age: _____
_____	Primary Language: _____	

Address (or name of current placement):	Last Agency to Provide Ongoing Services:
_____	_____ ☐ Closed ☐ Currently Open

Referral: ☐ WSH ☐ Local jail ☐ NSRSN ☐ ECS
☐ LTR _____
☐ Hospital _____
☐ Other, specify _____

Individual Completing Screen (print): _____

(signature): _____

Contact Phone: E-mail:

Diagnosis: (Complete all w/ description / code. Please INCLUDE Substance Use Disorders)

	Code:
	Code:
	Code:
	Code:
	Code:
	Code:
	Code:
	Code:
	Code:

Fax to 360-416-7017

Note: Screenings occur 1 time per week. Snohomish PACT screenings are held on Thursday afternoons and Skagit PACT screenings are on Tuesday mornings. Referrals submitted after the designated screening time will be screened the following week.

Admission Criteria

1. For admission to a Program for Assertive Community Treatment (PACT) team, an individual must meet the following admission criteria.
2. Individual must be medically stable (e.g. does not need extensive individual nursing care or skilled nursing facility placement).
3. The individual has a diagnosis of severe and persistent mental illness. Priority is given to a diagnosis of schizophrenia, other psychotic disorders (e.g. schizoaffective disorder) and bipolar disorder because these illnesses more often cause long-term disability. If other diagnosis, please explain/justify*:
4. The PACT model has been explained to the individual and they have agreed to be screened for services.

   **The PACT teams cannot accept an individual whose sole or primary diagnosis is Dementia, a Personality Disorder, Pervasive Developmental Disorder and/or Substance Abuse/Dependency. Such disorders, however, do not exclude an individual with a severe and persistent mental illness.*

5. The individual experiences significant functional impairments due to mental illness as demonstrated by the following conditions: *(Please check all that apply)*

   ☐ Significant difficulty maintaining consistent employment at a self-sustaining level.

   ☐ Significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).

   ☐ Significant difficulty in consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene).

   ☐ Persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

   ☐ Significant difficulty maintaining a safe living situation (e.g. repeatedly forgetting to turn stove burners off; excessive hoarding; consistently unsanitary conditions due to uncollected garbage, food scraps and other waste material).

6. Continuous high-service needs due to mental illness demonstrated by the following: *(Please check all that apply)*

   ☐ High use of psychiatric hospitals (e.g., two or more admissions of more than 72 hours' duration in past year, or sixty or more total days spent in hospital in past year, or a single stay of 30 or more days' duration in past year).

   ☐ Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).

   ☐ Co-occurring substance use disorder of significant duration (e.g., greater than six months).

   ☐ High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).

   ☐ Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness.

   ☐ At imminent risk of becoming homeless (e.g., repeated evictions or loss of housing).

   ☐ Residing in an inpatient, jail or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided.

   ☐ Requiring a residential or institutional placement if more intensive services are not available.

   ☐ History of medication non-adherence and or treatment non-compliance.

Client Name/ID/DOB *(or affix label)*

Please explain the need for PACT level of services.

Why is the current level of care unable to meet individual's needs?

How would PACT provide more support than what us being offered?

What isn't working with their current treatment?

Provide current Treatment Plan ☐ Yes ☐ No

Is individual interested in Agency sponsored housing? ☐ Yes ☐ No
If no, where will the individual live? Address:

Is the Individual on Housing waiting list? ☐ Yes ☐ No

If Yes, where: _____

Do any require regular follow up? ☐ Yes ☐ No

History of Hospitalizations and Law Enforcement Contacts

(Please complete even if admission criteria in these areas are not met)

Psychiatric hospitalizations for the last 2 years

Hospital Name & Location *(if known*	ITA/Voluntary	Admission Date	Discharge Date

Client Name/ID/DOB *(or affix label)*

_____

Other relevant information regarding hospitalizations, if any:

All known legal contact (incarcerations, arrests or other law enforcement contacts), with details as available.

Date of Arrest	Facility Name, Location, City & State	Incarceration Date	Release Date	Charge(s)/Description of Contact

Are there any outstanding legal matters? CPS, Civil, Criminal ☐ Yes ☐ No
If Yes, please provide the following:

Type: _____

County: _____

Upcoming Court Dates _____

Does the current Case Manager assist with transportation or are they involved in any way?

☐ Yes ☐ No _____

Does the individual have natural supports? ☐ Yes ☐ No

Formal Supports? ☐ Yes ☐ No

Does the individual have any of the following:

- ☐ Medicaid
- ☐ SSI or SSDI
- ☐ Food Stamps
- ☐ HUD
- ☐ Community supports/ assistance
- ☐ Payee
- ☐ Are they able to ride a bus
  - ☐ Have a Dial-a-Ride or Hopelink

Client Name/ID/DOB *(or affix label)*

_____

Is the individual on an LRA ☐ Yes ☐ No

If Yes, when does it expire (Date): _____

Does the individual have a Primary Care Provider? ☐ Yes ☐ No

Do they have any outstanding issues that need to be addressed immeadiately? ☐ Yes ☐ No

If, Yes, please provide information:

Medications:

Medication Name	Dose	Reason	Prescriber

Current Psychiatric prescriber _____ Phone: _____

Address _____

Fax _____

Current Funding Source: ☐ Medicaid ☐ None ☐ Other: ____

Please attach the follow required information:

- Most recent psychiatric evaluation
- Most recent assessment / updates, if client is an enrolled Outpatient

Client Name/ID/DOB *(or affix label)*

_____

Client Signature

Name *(please print)*

Date

Client Name/ID/DOB *(or affix label)*