Upper Bay Counseling & Support Services, Inc.

MOBILE TREATMENT SERVICES (MTS)

REFERRAL PACKET

The Referral Process

Referrals to Mobile Treatment Services (MTS) will be accepted from professionals/providers of treatment and/or any other agency/hospital involved in the provision of Behavioral Health Services.

MOBILE TREATMENT SERVICES-CRITERIA FOR ELIGIBILITY

Part 1: Must meet ALL criteria in Part 1 to be eligible for MTS		
	Yes	**No**
Adult (18 years of age or older)		
Diagnosis: Individuals with a priority population diagnosis in the DSM V. Individuals with a primary diagnosis of substance use disorder, mental retardation, or brain injury are not the intended consumer group.		
Difficulty utilizing traditional cases management or office based outpatient services or evidence that they require more assertive and frequent non-office based services to meet their clinical needs.		
Part 2: Must meet two (2) out of the six (6) criteria in Part 2 to be eligible for MTS Admission Criteria:		
A minimum of two psychiatric hospitalizations in the past 12 months or multiple ED visits for psychiatric reasons		
Intractable (persistent or very recurrent) severe major symptoms (affective, psychotic, suicidal)		
Co-occurring mental illness and substance use disorders more than six (6) months duration at the time of contact		
High risk or recent history of criminal justice involvement which may include frequent contact with law enforcement personnel, incarcerations, parole or probation.		
Literally homeless, imminent risk of being homeless, or residing in unsafe housing.		
Residing in an inpatient or supervised community based residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring residential or institutional placement if more intensive services are not available.		

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ADMISSION REFERRAL FORM

Note: This form must be completed in its entirety and submitted with ALL supportive documentation: Psychiatric evaluation, Copy of current MA card, Treatment history, psychosocial history, Copy of recent lab results, recent progress notes and any other documentation which will support the individual's eligibility for Mobile Treatment Services. Whichever criteria the consumer meets MUST be supported by documentation or the referral will be incomplete and the assessment will not occur.

Date of Referral: _____

I. General Consumer Information

Name (Last, First, Middle): _____

Maiden/Other Name(s): _____

Address: _____ County: _____
Phone:_____

Sex (Circle One) Male Female Age:_____ Date of Birth: _____

Social Security Number:_____-___-_____ Marital Status:_____

Primary Language: _____ Religious Affiliation:_____

Medical Assistance Number: _____ Category of assistance:_____

If currently hospitalized: Name of hospital: _____

Date Admitted: _____

Social worker: _____ Telephone: _____

Projected D/C Date: _____

Interested family member/friend: Name_____

Address_____

Telephone_____

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Presenting
Problem:_____
_____
_____

Reason for
Referral:_____
_____
_____

Has this referral been discussed with consumer Yes_____ No_____

Has the consumer agreed Yes_____ No_____

II. Identifying Information

Hair Color:_____ Eye Color:_____ Height:_____ Weight:_____

Glasses:_____ Contact Lenses:_____

Dentures:_____ Upper:_____ Lower:_____ Needed

Hearing Aid:_____ Other Prosthesis:_____ Physical Limitations:_____

III. Current Medical Information

Current Diagnosis (DSM V): Disorders and Conditions (Previously Axis I-III)
_____

_____

Important Psychosocial and Contextual Factors (Previously Axis IV) _____

_____

Psychiatrist: _____Address:_____

Telephone: _____

Community and state hospitalizations (List/date any hospitalizations within the last 12 months)

_____

_____

_____

_____

_____

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Current Medications / Dosages / Frequency: Requires Monitoring: _____Yes _____No

_____ _____

_____ _____

_____ _____

_____ _____

Allergies /Medications / Substance: _____ Reaction: _____

Clozaril Treatment (if applicable)

Date began Treatment: _____ Where: _____

Present treatment facility: _____ Dosage: _____

How is Clozaril being monitored at present? _____

Primary Physician: _____ Address: _____

Telephone: _____

Dentist: _____ Address: _____

Telephone: _____

Neurologist: _____ Address: _____

Telephone: _____

Other Doctor:_____ Address: _____

Telephone: _____

Current medical condition (acute or chronic medical problems). Current medications for medical problem and family history of/or current medical problems:_____
_____
_____
_____

IV. Current/previous treatment history

Is there any current involvement with mental health services? _____Yes _____No

Length of service: _____

Which County is involved with individual: _____

Total number of State hospital admissions: _____

List prior treatment facilities (out-patient, partial hospitalization, etc… include outcome and consumer's participation)_____
_____
_____
_____

V. Drug and alcohol History

Substances used (frequency, evaluations, treatment, and treatment effectiveness for both family and consumer)

_____
_____
_____
_____
_____

VI. Financial Information

Source(s) of Income: _____

Amount of Monthly Income: _____

Has SSI / SSD / MA Application been started? _____ By Whom: _____

Other sources of income (include any bank accounts or life insurance policies):
_____
_____
_____

Does individual have a Rep-Payee? _____Yes _____No _____One is needed

If Yes, Name _____ Address: _____

Relationship: _____ Agency: _____

Telephone: _____

Does Individual have a guardian? _____Yes _____No _____One is needed

If Yes, Name _____ Address: _____

Relationship: _____ Agency: _____

Telephone: _____

VII. Social History

Does individual have a secure living arrangement? _____Yes _____No _____One is needed

If No, where is individual currently living? _____

Describe any problems with past living arrangements? (Ex….Past due rent, property damage, etc…)

_____
_____
_____

Where would the individual prefer to live: _____

Are these living arrangements possible/available: _____

Are there any family supports available: _____

Any family history of mental illness: _____Yes _____No If yes, who? _____

Any criminal/legal history? _____Yes _____No If yes, explain

_____

History of behaviors (include when, toward whom, and if weapons were involved)

Assaultive/Aggressive_____

Homicidal _____

Suicidal_____

Physical Abuse_____

Sexual Abuse_____

Fire Setting_____

VIII. Educational/Vocational History

Completed Grade level: _____ College or Vocational? _____

Currently Employed? _____Yes _____No If yes, where? _____

_____part-time _____full-time _____hours/days working

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IX. Other relevant information about being referred for MTS and their need for MTS services

_____

_____

Please forward all completed referral forms and supporting documents to:

Ronnie Drake, LCPC, Program Director

UBCSS

200 Booth Street Elkton, MD 21921

Or fax to 410-996-5197

Name of person completing referral _____

Agency/Hospital:_____

Date: _____

Date Received: _____

Disposition of Referral:

_____

_____

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