PACT Team Referral

First Name: _____ Middle Initial:_____ Last Name:_____

Maiden Name:_____ DOB: _____ SS#:_____

Address:_____ Phone: _____

Other Contact Information: _____

Medicaid #: _____ Medicare #: _____ SSI ____ SSDI____

Allergies and/or Medical Conditions:_____

Referral Sent (X):	Counties Served	Agency	Phone	Fax
	Pontotoc, Garvin, Murray	Ada CMHC	580-332-3699	580-421-9828
	Coal, Atoka, Pittsburg, Latimer	Carl Albert CMHC	918-426-7854	918-426-1576
	Oklahoma	Red Rock BHS	405-425-0341	405-425-0313
	Pottawatomie	Red Rock BHS	405-878-1135	405-878-1138
	Oklahoma	North Care	405-858-2970	405-858-1775
	Tulsa	Family & Children's	918-599-7404	918-584-2530
	Tulsa- CO-PACT	Family & Children's	918-582-7228	918-382-1881
	Tulsa-IMPACT	University of Oklahoma	918-660-3150	918-660-3143
	Cleveland, McClain	Central Oklahoma (COCMHC)	405-573-3955	405-573-3966
	Comanche, Cotton	Jim Taliaferro JTCMHC	580-248-5436	580-248-9128
	Kay	Grand Lakes	918-418-3102	
	Payne	Grand Lakes	918-418-6419	

Sending records from your facility with the referral will help us determine eligibility.

**** Without records, we must first obtain a Release of Information and request records, which could delay the process.*

Priority shall be given to those with a primary diagnosis of Schizophrenia, Schizoaffective, or Bipolar Disorder with psychotic features. *Individuals with a primary diagnosis of substance abuse, traumatic brain injury or Axis II disorders are not appropriate for PACT.*

Diagnosis - Include substance abuse/dependency

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

Current Medications:

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

Previous Admissions

Hospital/Jail/RCF	Admit Date	Discharge Date	Reason for admission
1.	/		
2.	/		
3.	/		
4.	/		
5.	/		
6.	/		

Admission Criteria

4 psychiatric hospitalizations in the past 24 months or lengths of stay *totaling* over 30 days in the past 24 months. Time spent in jail, prison and/or residential care facilities will be considered.

Plus 3 of the following:

____ Persistent or recurrent severe affective, psychotic or suicidal symptoms

____ Homeless, imminent risk of losing housing or living in substandard/unsafe housing OR residing in supported Housing but clinically assessed to be able to live in a more independent living situation if intensive services are provided.

____ High risk of or criminal justice involvement in the past 12 months (please list arrest/release date and place) ____

_____

____ Probation? _____ Parole? _____

____ Inability to consistently perform the range of practical daily living tasks required for basic adult functioning

____ Inability to participate in traditional office-based services

____ Co-existing substance abuse disorder greater than 6 months – Drug(s) of choice: _____

History of Violent/Aggressive Behavior:_____

_____

Symptoms & Behavioral Challenges (risk of harm to self or others, etc):_____

_____

Other issues affecting treatment. (Substance use w/drug of choice, employment, and family involvement):_____

_____

Physical Health Issues:_____

_____

Please note: this referral should be forwarded to the program designated to serve the consumer's respective service area.

- Please attach a copy of the latest psychiatric evaluation and other pertinent information that may be helpful.
- **Attach Releases of Information for ALL prior hospitalizations.**
- Referrals which do not contain all releases and information needed may take longer to process.
- Please phone the team if you have questions regarding the referral process.
- Out of courtesy, please indicate ALL teams you have sent the referral to so we may collaborate on the effort.

Referred By: _____ Agency: _____ Date:_____

Phone: _____Email: _____ Fax: _____