Name of participant: ____________________________
Date of birth: ________________________________
Prime number (*if applicable*): ____________________

Oregon Health Authority
HEALTH SYSTEM DIVISION

Assertive Community Treatment (ACT)

Universal Referral Form

Date form is sent: _____________
Referring party name and title: ____
Referring party agency contact information: ______________________________________

Type of request:
☐ **New referral:** Clinical notes attached? ☐ Yes ☐ No. If no, why? ______________________
☐ **Transfer.** ACT Program Transferring from and contact: ______________________________

Current location: ______________________________ Participant phone number: ______________
Address/anticipated address: ____
Anticipated county to reside: ____
Gender identity preferences: ____
Cultural identity: ______________________________ If Tribal, what tribe: _________________
Linguistic preferences: ____
Guardian primary contact: _________________________ Guardian phone number: ______________
Home CCO/insurance type: ____
Primary mental health diagnosis: ____
Most recent clinical assessment: ____
Who completed assessment: ____
Aid and assist: ☐ Yes ☐ No Anticipated discharge date: __________________

Note: per OAR 309-019-0245(1)(b), Individuals with a primary diagnosis of a substance use disorder, borderline personality disorder, autism spectrum or intellectual disabilities are not the intended population for ACT.

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1. Does the client exhibit significant functional impairments as demonstrated by at least one of the following conditions?

   ☐ Significant difficulty 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, or housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs, maintaining personal hygiene.*) Briefly describe:

   ____

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- ☐ Significant difficulty maintain consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (*e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities*). Briefly describe:

  ____

- ☐ Significant difficulty maintaining a safe living situation (*repeated evictions or loss of housing*). Briefly describe:

  ____

2. Does the client have a secondary co-occurring disorder that also impacts their ability to function in the community?
   Substance use disorder: ☐ Yes ☐ No. If yes, please list: ______________________________
   Other co-occurring disorder: ☐ Yes ☐ No. If yes, please list: ______________________________

3. Client with one or more of the following indicators of continuous high service needs (*check all that apply*):
   - ☐ High use of acute psychiatric hospitals (Two or more admissions per year) or psychiatric emergency services.
   - ☐ Intractable (e.g., persistent, or very recurrent) severe major mental health symptoms (*affective psychotic, suicidal*).
   - ☐ Coexisting substance use disorder of significant duration (*greater than six months*).
   - ☐ High risk or recent history of criminal justice involvement (*e.g., arrest, incarceration*).
   - ☐ Significant difficulty meeting basic survival needs, residing in substandard housing, houselessness, or imminent risk becoming houseless.
   - ☐ Residing in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
   - ☐ Difficulty effectively utilizing traditional office-based outpatient services.

Additional information
(*Other programs involvement/referrals or any other identifying factors that will assist in transition*)

ACT program (or SPOC) determination

Date referral received: ________________

Accepted for next steps of review:

- Anticipated date of intake/screening evaluation: ________________
- Waitlisted: ☐ Yes ☐ No

Pending (*list reason for selecting this*): ________________

Denied (*list relevant OAR's*): ________________

- If denied, please identify alternative recommendations of community-based services to be provided:

________________________________ ________________

Signature of ACT Services Representative **Date**

(*Whomever made final determination*)

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Adult Mental Health Program at languageaccess.info@odhsoha.oregon.go or 1-844-882-7889 (voice). We accept all relay calls.