State of Hawaii
Department of Human Services, Med-QUEST Division
Clinical Standards Office

REFERRAL FOR COMMUNITY CARE SERVICES (CCS)

Be sure to complete.

MEMBER CONSENT for 1157 referral:	☐ Verbal consent obtained for 1157 or ☐ Written consent – *please attach*
☐ *Legal guardian/POA/Surrogate (If applicable) - written consent obtained (signed/dated) with legal documents – please attach*	

Section A: Fill in information. If certain areas are left blank, the referral may be returned.

1. MEMBER LAST NAME	2. MEMBER FIRST NAME	3. GENDER

4. DOB	5. MEDICAID ID#	6. MEDICAID HEALTH PLAN	7. ISLAND/AREA

8. CIS +	8a. ADDRESS (#, Street/Apt, City, State, Zip) If ***none, "N/A or approximate location/area frequented***
☐ YES ☐ NO	

8b. MAILING ADDRESS (#, Street/Apt, City, State, Zip) If ***same as 8a, "same"***	9. PHONE #

10. PRIMARY CCS ELIGIBLE SMI/SPMI DIAGNOSIS (***See pg. 3 of 1157 Instructions for list***)	11. DX CODE

12. SECONDARY DX (***If none, "N/A"***)	13. DX CODE

14. MEDICAL DX (***If none, "N/A"***)

15. CURRENT HOSPITAL ADMIT	16. HOSPITAL/ADMITTING DX	17. ADMIT DATE
☐ YES ☐ NO		

18. CURRENT PRESCRIBED PSYCH MEDICATIONS
☐ YES ☐ NO ***If YES, provide list on page 3 "MEDICAL/PHYSICAL" or provide a list in the supporting documents.***

19. PRIMARY CARE PHYSICIAN (PCP)	20. CURRENT PSYCH PROVIDER(S) *(i.e., Psychiatrist, psychologist, therapist)*

Section B: **DO NOT fill out. MQD/CSO use only.**

Evaluation DATE: _____ CCS ENROLLMENT DATE: _____

DETERMINATION				
☐ APPROVED			☐ DENIED	☐ ADDITIONAL INFORMATION
RE-EVALUATION DATE:		☐ NONE		

COMMENTS, additional information request, or reason for denial: _____

MQD MD NAME:	MQD MD SIGNATURE

Section C: Functional Impairment

I. MENTAL STATUS: Check all that apply. If "other" is checked off, please provide a brief description. If sections do not apply, please document "NA" in the "Description". If sections are left blank, the referral will be returned.

GENERAL	
Appearance:	☐Within normal limits ☐Other
Dress:	☐Appropriate ☐Bizarre ☐Clean ☐Dirty ☐Other
Grooming:	☐Neat ☐Disheveled ☐Needs Improvement ☐Other
Description:	

BEHAVIOR	
Eye Contact:	☐Good ☐Fair ☐Poor ☐Other
Posture:	☐Good ☐Slumped ☐Rigid ☐Other
Body Movements:	☐No Issues Noted ☐Involuntary ☐Akathisia ☐ Other
Description:	

SPEECH
☐Clear ☐Mumbled ☐Rapid ☐Whispers ☐Monotone ☐Slurred ☐Slow ☐Loud ☐Constant ☐Mute ☐Other
Description:

MOOD
☐Anxious ☐Fearful ☐Friendly ☐Euphoric ☐Aggressive ☐Hostile ☐Depressed ☐Calm ☐Other
Description:

AFFECT
☐ Full Range ☐Flat ☐Constricted ☐Inappropriate ☐Other
Description:

THOUGHT	
Process of Form:	☐No Issues Noted ☐Loose Associations ☐Poverty of content ☐Flight of ideas ☐Neologism ☐Perseveration ☐Blocking ☐Other
Content:	☐Delusions ☐Thought broadcasting ☐Thought insertion ☐Thought withdrawal ☐Other ☐NA
Description:	

HALLUCINATIONS
☐ NA ☐Auditory ☐Visual ☐Tactile ☐Somatic ☐Other
Description:

REALITY ORIENTATION	
Orientation:	☐Person ☐Place ☐Time ☐Other:
Memory:	☐Recent intact ☐Remote intact ☐Other:
Description:	

INSIGHT
☐Aware of illness/impairment ☐Denies illness/impairment ☐Other
Description:

JUDGEMENT
☐Good ☐Fair ☐Poor ☐Other
Description:

II. FUNCTIONAL SCALES: Please provide detailed explanations of functional impairment. If the area does not apply to the member, please fill in the blank with N/A. If spaces are left blank or insufficient information is provided, the referral will be returned.

RECENT PSYCHIATRIC/BEHAVIORAL HEALTH HOSPITALIZATIONS and/or ER VISITS ***(Within the past year)***
FAMILY/LIVING
INTERPERSONAL RELATIONS
ROLE PERFORMANCE
SOCIO-LEGAL (e.g. any prior/recent, probation, parole) If any current LEGAL ENCUMBRANCES, **STOP**, referral will **NOT** be processed.
SELF-CARE/BASIC NEEDS

SECTION D: To be signed or verified by a QMHP. Be sure to provide QMHP title *(See list of QMHPs in 1157 Instructions)*

PRINT NAME	TITLE
SIGNATURE	**DATE**
EMAIL	**PHONE#**
QMHP Verification/Co-sign PRINT NAME	**QMHP TITLE**
QMHP Verification/Co-sign SIGNATURE	**DATE**