REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

CLIENT NAME _____ ☐ MALE ☐ FEMALE
Last First M.I.

HOME ADDRESS _____ PHONE NO. _____

_____ CASE NO. _____

MAILING ADDRESS _____ CLIENT ID NO. _____

_____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ AGE _____ COUNTY ☐ OAHU ☐ HAWAII ☐ MAUI ☐ KAUAI

HEALTH PLAN: ☐ UNITED HEALTHCARE ☐ OHANA ☐ ALOHA CARE ☐ HMSA ☐ KAISER FOUNDATION

PRIMARY DIAGNOSIS _____ DSMIV CODE _____

SECONDARY DIAGNOSIS _____ DSMIV CODE _____

CURRENT MEDICAL CONDITIONS (Indicate, if none) _____

_____

DATE OF REFERRAL: _____ NAME OF PCP: _____ PCP NOTIFIED: Y ☐ N ☐

HOSPITALIZATIONS	**CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** _____ *(list)* **Admitted on** _____/_____/_____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis
MEDICATIONS	Strength	Dosage	Start Date	End Date
OUTPATIENT THERAPISTS	Diagnosis		Start Date	End Date

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services_____

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed

Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____

_____

_____

Signature: _____

FOR ADULTS ONLY

Client Name: _____ Client I.D. No.: _____

I. MENTAL STATES

A. General:

1. Appearance: Within Normal Limits [ ] Other [ ] _____
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs improvement [ ]

B. Behavior:

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] _____
3. Body Movements: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] _____

C. Speech: Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] _____

D. Mood: Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] _____

E. Affect: Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]
Other [ ] _____

F. Thought:

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ]
Thought insertion [ ] Thought withdrawal [ ] Other [ ] _____

G. Perception – Hallucinations:

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. Reality Orientation:

1. Mark all areas which the recipient can name:
Time: Day [ ] Month [ ] Year [ ]
Place: (can describe location) Yes [ ] No [ ]
Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] Remote intact: Yes [ ]
No [ ] No [ ]

I. Insight: Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. Judgment: Good [ ] Fair [ ] Poor [ ]

FOR ADULTS ONLY

Client Name: _____ Client I.D. No.: _____

II. FUNCTIONAL SCALES: *(Check and specify any problem(s) in the following areas)*

[ ] **Medical/Physical**

_____

_____

[ ] **Family/Living**

_____

_____

[ ] **Interpersonal Relations**

_____

_____

[ ] **Role Performance**

_____

_____

[ ] **Socio-Legal**

_____

_____

[ ] **Self-Care/Basic Needs**

_____

_____

III. **SUPPORTING DOCUMENTATION:** Please supply additional comprehensive information and assessments (if available) which would be of assistance in the evaluation of the criteria for eligibility.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name)*: _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients *(Print Name)*: _____