



ACT Referral Form

Submit forms at *CIL.ACTReferrals@centerstone.org* or call 1-877-467-3123

Today's Date: _____

Referral Source/Name: _____ Phone Number: _____

Client's Name: _____ Gender: _____

Date of Birth: _____ Social Security: _____

Race: _____ Ethnicity: _____

Phone Number for Person Being Referred: (_____) _____ OK to leave message? YES NO

Type of Insurance: _____ Insurance ID: _____

Guardian Consent Received? YES NO N/A

County? Madison St. Clair Jersey Jackson Other

Guardianship Status: Own Guardian Court Appointed Guardian Other explain: _____

Interpreter Services: None Required TDD/TYY American Sign Language Other explain: _____

Preferred Language: _____

DSM 5/ICD Diagnosis (the following are the qualifying diagnosis, please select at least one):

Schizophrenia Disorder Schizophreniform Disorder Schizoaffective Disorder

Delusional Disorder Shared Psychotic Disorder Brief Psychotic Disorder

Psychotic Disorder NOS Bipolar Disorder

Significant Functional Impairments (please select at least one of the following):

Consistent inability to perform daily tasks needed to function in the community (maintain hygiene, meet nutritional needs, and obtain medical services).

Persistent failure to perform daily living tasks except with significant support from others.

Consistent inability to be employed at a self-sustaining level.

Inability to maintain a safe living situation (e.g. repeated evictions or loss of housing).

Indicators for Continuous High-Service Needs (select all that apply)

High use of acute psychiatric hospitals (e.g., 2 or more admissions per year) and/or psychiatric emergency services (e.g., 3 or more per year). **Specify the # of admissions over the past two years and/or the # of emergency contacts in the past two years. List here:** _____

Intractable severe major symptoms (e.g., affective, psychotic, suicidal).

Co-existing substance use disorder of significant duration (e.g., greater than 6 months).

High risk or a recent history of being involved in the criminal justice system.

The individual is residing in substandard housing, homeless, or imminent risk of becoming homeless.

Living in an inpatient bed or in a supervised community residence but clinically assessed to be able to live more independently if intensive services are provided.

Inability to participate in traditional office-based services.

For Internal Use Only: Please Indicate LOCUS Score: