# DHHS- Office of Adult Mental Health Services
# UNIVERSAL PNMI REFERRAL/APPLICATION FORM

**Date: _____** **AMHI Class Member? ☐YES ☐NO**

**Consumer Name:_____ Gender: ☐ Male ☐ Female ☐Transgender**

**Current Address_____**

**Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed**

**D.O.B.:_____ Social Security Number_____**

**Income Source_____ Amount_____ MaineCare Number:_____**

**Maine Care Status: ☐ Categorical ☐ Non- Categorical ☐ Applied/Pending _____ (date applied)**
**☐ Spend Down _____(amount) _____(deductible dates) ☐ Other Insurance**

**Housing Subsidy (BRAP, Shelter + Care, Section 8)? _____ No/ Applied-Pending _____(Date)**

**Referral Source: _____ Phone: _____ Contact Person: _____**

**Referent E Mail Address: _____**

**In which CSN does the consumer want to live?**

**☐ 1. Aroostook**
**☐ 2. Hancock, Washington, Penobscot, and Piscataquis**
**☐ 3. Kennebec and Somerset**
**☐ 4. Knox, Lincoln, Sagadahoc, and Waldo**
**☐ 5. Androscoggin, Franklin, and Oxford**
**☐ 6. Cumberland**
**☐ 7. York**

**Referral is for (Primary PNMI program choice):_____ (Secondary Choice) _____**

**Reason for referral:**

_____
_____
_____
_____
_____

**Does the consumer have any special considerations/needs to be considered for this referral?**
**☐ Yes ☐ N**
**If yes, please note: ☐ Awake night staff ☐1:1 ☐ handicap accessible ☐ medical monitoring**
**☐ other _____**
_____
_____

**Please note any prior living arrangements and/or periods of homelessness. What worked? What didn't?**

_____
_____
_____

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**Does the consumer require ADL assistance:** □ **Yes** □ **No**
**If yes, explain:** _____
_____
_____

**Current Resources/Supports:**
**Does the consumer have a guardian?** ☐ **No** ☐ **Public** ☐ **Private** ☐ **Under Study**
**Is the guardianship** ☐ **Full** ☐ **Limited Explain:** _____
**Guardian contact first and last name:**_____
**Guardian Telephone Number:** _____
**Does the consumer want the services being requested?** □ **Yes** □ **No**
**If no, please explain:**_____
_____

**Does the consumer have a Rep Payee?** ☐ **Yes** ☐ **No**
**If yes, contact first and last name:** _____
**Rep Payee Telephone Number:** _____

**Does the consumer have a case manager?** ☐ **Yes** ☐ **No**
**If yes, case manager first and last name:**_____
**Case Management Agency and Telephone Number:** _____

**Does the consumer have a Primary Care Physician?** ☐ **Yes** ☐ **No**
**If yes, name of Primary Care Physician:** _____
**PCP Telephone Number** _____

**Family and/or Other Supports (any other pertinent psychosocial information):**
_____
_____
_____

**What has family involvement been with consumer?**
☐**Phone** ☐**Visits** ☐ **Treatment Sessions** ☐ **Other** ☐ **Consumer Refuses** ☐**Other**

**Is there a current contact person? (please list name and telephone number):**_____
_____

**LEGAL ISSUES:**
**Does the consumer have any current legal issues/charges?** ☐ **Yes** ☐ **No**
**If yes, explain:**_____
_____
**Does the consumer have any past legal issues?** □**Yes** □ **No**
**If yes, explain:**_____
_____
**Is the consumer involved with pre-trial?** ☐ **Yes** ☐ **No**
**Does the consumer have a probation officer?** ☐ **Yes** ☐ **No**
**If yes, probation officer name:** _____**Telephone Number:**_____
**Does the consumer have conditions of release?** □ **Yes** □ **No**
**If yes, explain?** _____
_____

**Consumer Name:** _____

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**DIAGNOSIS**

**Axis I.** _____ _____
_____ _____
**Axis II:** _____ _____
**Axis III:** _____
**Axis IV:** _____
**Axis V: GAF**_____
**Current LOCUS Score:**_____
**Date Diagnosed:** _____ **Name and License Level of Diagnostician:** _____

**CURRENT SYMPTOMS:**_____
_____
_____

**Suicidal?** Y☐ N☐ **If Yes,** ☐**Ideation** ☐**Plan** ☐**Means** ☐**Intent** ☐**Attempt** ☐**Hx of Attempts**

**Homicidal?** Y☐ N☐ **If Yes,** ☐**Ideation** ☐**Plan** ☐**Means** ☐**Intent** ☐**Attempt** ☐**Hx of Attempts**

**Psychosis?** Y☐ N☐ **If Yes,** ☐**Delusional** ☐**Paranoid** ☐**Unable to Care for Self** ☐**Other**

**Hallucinations?** Y☐ N☐ **If Yes,** ☐**Auditory** ☐**Visual** ☐**Tactile** ☐**Olfactory**

**Depressed?** Y☐ N☐ **If Yes, check signs/symptoms:** ☐**Eating** ☐**Sleeping** ☐**Energy** ☐**Isolation** ☐**Weight Gain** ☐**Other somatic or vegetative symptoms**

**Are there other areas of risk not previously noted, such as elopement, self-injurious or assaultive behavior that would be helpful to know?** _____
_____
_____
_____

**Does the Consumer have any current Substance Abuse or Dependence Issues?** ☐ **Yes** ☐ **No**
**If yes, please check all that apply:**
☐ **Alcohol** ☐ **Cocaine/Crack** ☐ **Marijuana** ☐ **Ecstasy** ☐ **Over the Counter meds**
☐ **Sedatives/Hypnotics** ☐**Opiates/Pain Killers (Heroin, Methadone, Oxycontin, Oxycodone, etc.)**
☐**Tobacco** ☐ **Caffeine** ☐ **Amphetamine/Methamphetamine** ☐ **Benzodiazepines**
☐ **Other Street Drugs** ☐**Other:** _____

**Dates of onset?**_____**Current Amounts?**_____
**Dates of last use/remission?**_____
**Other Pertinent Substance Use or Dependence History:**_____
_____
_____

**CURRENT AND PRIOR TREATMENT (Mental Health and/or Co-Occurring):**
**Inpatient (please note name of hospital and dates):**
_____
_____
_____

**Consumer Name:** _____

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**Outpatient (please note agency name, provider names, and dates):**

_____
_____
_____

**Other:** _____
_____

**MEDICAL HX AND UPDATES (include relevant lab work and any known allergies):**

_____
_____
_____

**Has this person ever had a brain injury: □ Yes □ No**
**If yes, please explain:**_____
_____

**Medications (both psychiatric and medical/please note current / any recent changes/who prescribes the medications):**_____
_____
_____
_____

**Baseline behavior? How do you know when the client is doing well? Hobbies? Interests?**_____
_____
_____
_____

**Education History and Current Status:**_____

**Vocational History and Current Status:**_____
_____

**Please list any recent and pertinent assessments that have been done within the past three to six months such as Occupational Therapy, Neuropsychological, Psychosexual, or Psychiatric, or Psychological, including dates and assessor contact information or other relevant information.**

_____
_____
_____
_____

**Signature of Client** _____ **Date**_____

**Signature of Guardian** _____ **Date** _____

**Copy of referral given to consumer? Yes/ No/ Client Declined** **Date** _____

**Consumer Name:** _____