Anasazi: ______________________ MHS: ____________________

IHOT North Referral Intake Form

Complete all sections of this form & fax to IHOT North at (760) 591-0101 Attention: IHOT North Lead Clinician

REFERRING PARTY INFORMATION

Date of Referral:	Agency☐ Family☐ Other☐ Received and Logged by:	
Agency Making Referral:	Phone:	Fax:
Name of Person Making Referral:	Relationship:	

IDENTIFYING INFORMATION OF INDIVIDUAL REFERRED

Name:		**DOB**:
Gender:	Race/Ethnicity:	Language Preference:
Address: **Zip Code**:		Phone:

Family Contact Information: Family Address: City: Zip Code:	Relation:	Phone: Family is aware of IHOT North referral? YES ☐ NO ☐ Does the potential participant live at home Or with referring party? YES ☐ Possibly NO ☐ Homeless☐
Employed: YES☐ NO ☐ (If known)	**Veteran:** YES☐ NO☐ (If known)	**Level of Education**: HS Grad☐ College☐ Other☐________________ (If known)

REASON FOR REFERRAL (Describe each area below)

Anasazi: ______________________ MHS: ____________________

Chief Complaint:

Mental health History (include Substance use):

History of Family & Individual Relationship:

Individual's Strengths:

Barriers to individual receiving services:

Is this person interested in mental health services? Yes☐ No☐ Unknown☐

Family Goals for IHOT North:

1.

2.

3.

Would they like a Family Specialist? ☐ Yes ☐ No ☐ Uncertain at this time

CLINICAL INFORMATION ON CONSUMER (complete this section **if information is available**)

DIAGNOSIS		
Axis I	(Primary):	(Secondary):
Axis II:		
	Source of Information: Referring Party:____________ Anasazi: ________ Other: __________________________	

Does the potential participant currently have a Substance Abuse related Diagnosis? ☐ Yes ☐ No

Physical Health Complications:

Number of Psych Hospitalizations in the Last 3 Years: Reasons:

Number of Psych Hospitalizations in the last 12 months: Reasons:

Number of Incarcerations (jail stays more than 24 hours) **in the Last 3 years:**

Number of Incarcerations (jail stays more than 24 hours) **in last 12 months:**

Anasazi: ______________________ MHS: ____________________

Risk for Harm or Dangerous Propensities: (please check and describe, include dates of incidents)	
☐ Suicide (Ideation/Attempts)	
☐ Homicide (Ideation/Attempts)	
☐ History of Violence	
☐ Property Damage	
☐ Victimization	
☐ Severe Self Neglect	
☐ Sexual Predator	
☐ Potential Dangers for IHOT staff	
☐ Hx of Reckless Driving or DUI	
CURRENT PSYCHIATRIC MEDICATIONS:	
Psychiatrist Name:	Phone:
Primary Care Physician:	Phone:

FINANCIAL / INSURANCE INFORMATION

Payer Source: ☐ Medi-Cal ☐ Medicare ☐ Covered CA ☐ Private Insurance ☐Uninsured ☐VA Benefits ☐ SSI/SSDI ☐ CAL Fresh

PART A: Initial Determination	**Laura's Law**
1. 18+ years YES☐ NO☐ If NO referring party was informed not eligible ________	YES☐ NO☐
2. Principal Residence in an eligible zip code YES☐ NO☐ If NO referring party was informed not eligible _________	N/A
3. Potential participant is linked to services YES☐ NO☐ If YES referring party was informed not eligible _________	Has been offered an opportunity to voluntarily participate in a treatment plan by the local mental health dept. but continues to fail to engage in treatment. YES☐ NO☐
4. Other factors considered in determining eligibility YES☐ NO☐ Details:	History of non-compliance has either: Been a factor in hospitalization or incarceration at least 2X in last 36 months **OR** Resulted in one or more acts, attempts, or threats of serious violent behavior toward others or self in the last 48 months YES☐ NO☐

Anasazi: ______________________ MHS: ____________________

If not initially eligible, referrals offered: NAMI _____Family Support Group ______RI _______PERT _____Other _______	
Do follow up calls need to be made or additional information gathered?	YES☐ NO☐

If referral appears to be eligible move to Part B.

PART B: Record Found In Anasazi YES☐ NO☐

PART C: Secondary Determination for Eligibility **Laura's Law**

1. Description of symptoms or Anasazi indicates serious mental health problem with functional impairment. YES☐ NO☐	Is suffering from a mental illness. YES☐ NO☐
2. Other factors considered in determining eligibility YES☐ NO☐ Details:	Is substantially deteriorating. YES☐ NO☐ Unlikely to survive safely in the community without supervision, based on a clinical determination. YES☐ NO☐
3. Face to face assessment recommended YES☐ NO☐	In need of outpatient treatment to prevent a relapse or deterioration that would likely result in inpatient commitment due to threat of serious harm to self/others or grave disability. YES☐ NO☐
4. More information needed YES☐ NO☐ Details:	Likely to benefit from assisted outpatient treatment. YES☐ NO☐ Outpatient program is least restrictive placement necessary to ensure person's recovery and stability. YES☐ NO☐

Disposition: Not Eligible for Services at this Time _________________ Priority List ______________ Opened to Immediate Outreach _______________

Referring Party Informed (Date) _____________

Assigned to:_________________________/CM __________________________/FS ___________________________/PS Date ______________

Signature of Person Completing Referral:	**Date:**