Metro Crisis Coordination Program – Intake/Referral Form

All sections must be completed in order for a referral to be processed.
IT'S VERY IMPORTANT TO THOROUGHY ENTER ALL ADDRESSES INCLUDING THAT FOR THE SCHOOL/WORKSITE/DAY PROGRAM DUE TO THE RECENTLY INITIATED FEDERAL MANDATE FOR EVV (ELECTRONIC VISIT VERIFICATION) FOR APPOINTMENTS.

TODAY'S DATE

CLIENT INFORMATION

Name

Date of Birth

Gender

Social Security Number

Address

City

State **Zip**

Phone Number

County of Residence

REFERRAL INFORMATION

Type of Service *(check one)*:

- ☐ **Technical Assistance** *(case will be assigned to a positive support specialist to do an assessment)*
- ☐ **Crisis/Temporary Care bed placement** *(case will be assigned to a crisis placement worker)*
- ☐ **BOTH technical assistance & crisis/temporary care bed placement**

Referral Status:

- ☐ **First Time**
- ☐ **Reactivation**

Funding Source *(check one)*:

- ☐ **IDD/CDCS** ☐ **ICFMR** ☐ **CSG** ☐ **FSG** ☐ **CADI/CDCS** ☐ **TEFRA**
- ☐ **MA only** - *Will they be screened onto the waiver?* ☐ *YES* ☐ *NO* ☐ MR/RC Waiver ☐ **No funding**
- ☐ **CDCS** - *Has the guardian agreed to the cost to their budget?* ☐ *YES* ☐ *NO*

Is Interpreter Necessary for this case? ☐ *YES* ☐ *NO*

Reason for Referral:

Provide a description of the client's symptoms, events, and/or environmental situation/s that have led to this referral request.

Desired Outcomes (check all that apply):

- ☐ **Behavior Plan**
- ☐ **Crisis Bed**
- ☐ **Crisis Plan**
- ☐ **Day Program: Assessment and Considerations**
- ☐ **Day Program: Training**
- ☐ **Functional Behavior Assessment (FBA)**
- ☐ **Home: Assessment and Considerations**
- ☐ **Home: Training**
- ☐ **Nursing Consultation**
- ☐ **School: Assessment and Considerations**
- ☐ **School: training**
- ☐ **Staff Augmentation**
- ☐ **Transition Plan**

Greatest Risks *(check all that apply)*:

- ☐ **Breaks Laws**
- ☐ **Eats Non-Nutritive Substances**
- ☐ **Elopes**
- ☐ **Inappropriate Sexual Behavior**
- ☐ **Injurious to Self**
- ☐ **Risk of Loss of Placement**
- ☐ **Physical Aggression**
- ☐ **Property Destruction**
- ☐ **Verbal/Gestural Aggression**
- ☐ **Other**

Comments:

DIAGNOSIS INFORMATION

IDD Level *(please check)*:

☐ Borderline ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Profound** ☐ **Related Condition**

ID/DD Diagnosis ☐ **YES** ☐ **NO**

Allergies *(list all that apply)*:

Level of ADL's: ☐ **Independent** ☐ **Needs Assistance** ☐ **Needs Prompts**

Communication Level: ☐ **Limited** ☐ **Non Verbal** ☐ **Verbal** ☐ **Translator Needed** ☐ **English 2nd Language**

Primary Psychiatric Diagnosis (check all that apply)**:**

- ☐ Adjustment Disorder
- ☐ Anorexia Nervosa/Bulmia
- ☐ Anxiety Disorder
- ☐ Asperger's Syndrome
- ☐ Attention-Deficit/Hyperactivity Disorder
- ☐ Autistic Disorder
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder Conduct
- ☐ Disorder
- ☐ Depression
- ☐ Disruptive Behavior Disorder Dysthymic
- ☐ Disorder
- ☐ Encopresis
- ☐ Generalized Anxiety Disorder Impulse-
- ☐ Control Disorder, NOS Intermittent
- ☐ Explosive Disorder
- ☐ Major Depressive Disorder
- ☐ Mood Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Oppositional Defiant Disorder
- ☐ Panic Disorder
- ☐ Pedophilia
- ☐ Personality Disorder - Other
- ☐ Pervasive Developmental Disorder
- ☐ Postraumatic Stress Disorder
- ☐ Psychosis, NOS
- ☐ Reactive Attachment Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Selective Mutism
- ☐ Separation Anxiety Disorder
- ☐ Tourette's Syndrome
- ☐ Trichotillomania
- ☐ Other

Remarks:

Medical Diagnosis (check all that apply)**:**

- ☐ Alzheimer's
- ☐ Asthma
- ☐ Bladder/Bowel Abnormalities
- ☐ Blood Disorders
- ☐ Cardiovascular Abnormalities
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Cholesterol/High or Low Chromosomal
- ☐ Abnormalities
- ☐ Chronic/Recurrent Respiratory Disorders
- ☐ Dementia
- ☐ Dental/Oral Disorders
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ FAS/FAE
- ☐ Fragile X
- ☐ Gastrointestional Disorders
- ☐ Hearing Impairment
- ☐ Hyper/Hypo - Thyroidism
- ☐ Hydrocephalus
- ☐ Incontinence/Bladder/Bowel
- ☐ Metabolic Disorders
- ☐ Migraine
- ☐ Nutritional Concerns Parkinson's
- ☐ PKU (Phenylketonuria)
- ☐ Prader Willi
- ☐ Seizure Disorder
- ☐ Skeletal-Muscular Disorders Sleep
- ☐ Apnea
- ☐ Sleep Disturbance
- ☐ TBI
- ☐ Tuberous Sclerosis
- ☐ Vision Impairment
- ☐ Other

Remarks:

Misc. Info *(please check the following):*

	YES	NO
Client had Previous Psychiatric Hospitalization	☐	☐
Has a Behavior Support Plan	☐	☐
Has a Positive Support Transition Plan	☐	☐
Is taking Psychotropic Medication	☐	☐
Has an Individual Abuse Prevention Plan	☐	☐

List All Current Medications:

SUPPORT TEAM CONTACT INFORMATION

Guardian:

Name

Relationship

Email Address

Day Phone

Evening Phone

Mobile Phone

Street Address

City

State

Zip

Guardian's Legal Status:

☐ Self ☐ Private Guardian ☐ State Appointed

Additional contacts/info/comments:

Residential Supports:

Type of Residence *(check one)*: ☐ Family Home ☐ Group Home ☐ Foster Home ☐ ICF ☐ Own apartment/home ☐ Other

Support Type

Provider Company Name

Primary Contact

Title

Phone Number

Email

Fax

Secondary Contact

Title

Phone Number

Email

Fax

Comments:

CASE MANAGER

County of Financial Responsibility

Name

Address

City

State

Zip

Agency

Phone Number

Fax

Email

EDUCATION OR DAY SUPPORTS

School or Program Name

Contact Name

Email Address

Street Address

City

State

Zip

Phone Number

Mobile Phone

Additional Info

IF THE CLIENT IS CURRENTLY AT THE HOSPITAL

Name of Hospital

Admission Date

Primary Hospital Contact

Title

Phone Number

Additional info and/or additional contacts at the hospital *(please include name/title/phone number)*:

After this form is completed, please fax it to 612-869-6743 or email at mccp-referrals@mtolivet-mora.org along with the client's Individual Abuse Prevention Plan - or Health and Safety Plan, ISP - or similar case manager documentation - Attention to: INTAKE

MCCP will process this intake and assign it to a Positive Support Specialist who will make initial contact with team members.