**Commonwealth of Massachusetts**

**DEPARTMENT OF MENTAL HEALTH**

**DMH Respite Referral Form**

|  |  |
| --- | --- |
| **Site Based: [ ]**  | **Mobile: [ ]**  |

**To:**

|  |  |
| --- | --- |
| **Name:**       | **Respite Program:** Deaf Respite  |

**From:**

|  |  |
| --- | --- |
| **DMH Contact Name:** Sara Dugas |  **Phone:** 508-948-0605 |
|  **Address:** 167 Lyman St, Westborough, MA 01581 | **E-Mail:**  Sara.Dugas@state.ma.us |

**Individual Being Referred:**

|  |  |
| --- | --- |
| **Name:**        |  **EMR#:**       |
| **Phone:**        |  **D.O.B.:**       |
|  | **Gender:**       |
| **Home Address:**       |
| **Current Location:**       |
| **MassHealth Policy#** *(If applicable):*      |
| **Legally Authorized Representative (LAR)** *(if applicable)***:**       | **Phone**:       |
|  Mailing Address:       |
| **Name of Prescriber of Psychiatric Medications** *(if applicable)***:**       | **Phone**:       |
| **DMH Case Managed?**  | Yes [ ]  No [ ]  |
|  If “Yes,” Case Manager Name:       | **Phone:**       |
| **Enrolled in another DMH Service? Program?**  | Yes [ ]  | No [ ]  |
|  If “Yes,” Service Type:       | **Agency:**       |
|  Service Type Contact Name:       |  **Phone:**       |
|  Address:       |
| **Application for DMH Continuing Care Services in the Community** |
| Is Person Currently **Approved** for DMH Continuing Care Services in the Community? | Yes [ ]  | No [ ]  |
|  If “No” above, is a *Request for DMH Services* Pending? | Yes [ ]  | No [ ]  |
|  If Yes, **Date** of Application:       |
| **Dates and Reason for Referral *(choose only one option below)*:** |
| **Proposed Start Date**:       |  | **Projected Discharge Date**:       |
|  [ ]  Step Down from **Acute** Inpatient Facility | [ ]  Step Down from **DMH** Continuing Care Inpatient Facility |
|  [ ]  Diversion from Emergency Department | [ ]  Diversion from Continuing Care Inpatient Admission |
|  [ ]  Transfer from Acute CSU bed | [ ]  Diversion from Court as a 15a |
|  [ ]  Step Down From a Correctional Facility (jail/prison) |  |
|  [ ]  Other life interrupting need. Please Specify below *(e.g., domestic dispute, tenancy issues/eviction, etc.).*  |
| **Comments**:       |
| **Projected Outcome and Goals of the Respite Stay**:       |
| **Anticipated Length of Stay** (days):       |
| **Individual’s Preferences**:       |
| **Name:**       |
| **Mental Health and Substance Use Information:** |
| 1. **Statement of Current Situation**:       |
| 2. **Diagnoses** (Include psychiatric and medical diagnoses):       |
| 3. **Mental Status** **Narrative**:       |
| 4. **Medications** *(include current medications prescribed for both psychiatric and medical reasons)*:       |
| 5. **Substance Use/Abuse Issues** *(Please include substance(s) used, date of last use, toxicity screen results, and discharge plan if person uses while in the respite program):*       |
| 6. **Current Mental Health and Substance Use Providers** *(Please include name and contact information)*      |
| **Risk Behaviors:** |
| 7. **Risks to Self** *(Include information about current and relevant past self-injurious behaviors, suicidal ideations, suicidal attempts)*       |
| 8. **Risks to** **Others** *(Include information about current and relevant past assaultive behaviors ,homicidal and assault ideations)*       |
| **Name:**       |
| **Legal Issues:** |
| 9. **Legal Issues** *(Please include such information as pending charges, upcoming court dates and locations, probation officer contact information, problematic sexual behaviors, past convictions, etc).*       |
| 10**. Is person listed with** **Sex Offender Registry Board (SORB)**? | Yes [ ]  | (Indicate **Level**:       ) | No [ ]  |
|  |
| **Medical Information:** |
| 11. **Current Medical Providers** *(Please include Primary Care Physician (PCP) name and contact information)*       |
| 12. **Current Medical Conditions**:       |
| 13. **Allergies**:       |
| **Additional Information:** |
| 14. Is individual able to ambulate without assistance? | Yes [ ]  | No [ ]  |
| 15. Who will transport client to program?       |
| 16. Is individual arriving with two (2) weeks supply of medications? | Yes [ ]  | No [ ]  |
|  If “No” above, list date, time, and method of delivery of medications to program:       |
| **Information to be shared with DMH:** |
| Please send the following to:       |
| [ ]  Assessment & Treatment Plan | [ ]  IAP and Progress Reports |
| [ ]  Request to Extend Services Beyond Original Authorization | [ ]  Termination Summary at Conclusion of Services |
| [ ]  Other (specify):       |
|  |
| **Required DMH Signature** |
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| **The Following Section Must Be Completed By the Respite Program** |
| **Was Intake Completed?**  | Yes [ ]  | No [ ]  | If Yes, **Requested Enrollment Date**:      |
| **If Intake was NOT completed, please explain by checking one of the reasons below:** |
|  [ ]  Individual declined Respite Services. |
|  [ ]  Unsuccessful in making contact with individual. |
|  [ ]  Not Enrolled due to individual poses a significant and present threat to the general safety of Respite Services.  |
|  [ ]  Other *(Please explain):*       |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Respite Program Manager Date* |

***Confidentiality Notice:  Protected Health Information from the Department of Mental Health***

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