**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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