ACTT Referral Form

What is ACTT?
ACTT is a multidisciplinary clinical team that provides medical, counseling and case management services to assist individuals diagnosed with severe and persistent mental illness achieve stability in the community. The team consists of a psychiatrist, psychiatric nurses, clinical social workers, a substance abuse counselor, peer support specialist, team leader and program assistant who work together to provide services to the client. The goal of ACTT is to assist the client in maintaining his or her independence in the community and to remain out of the hospital. Services are intended to enhance overall quality of life through building self-confidence and competency across the domains of life functioning.

ACTT Target Service Group:

- Individuals diagnosed with severe and persistent mental illness that have experienced difficulty demonstrating sustained therapeutic gains through traditional mental health services.
- Individuals who have experienced multiple psychiatric hospitalizations and/or judicial involvement.
- Individuals who demonstrate an inability to consistently perform daily living skills necessary for successful community living due to their severe and persistent mental illness.

Contra-Indications for ACTT:

- Individuals with personality disorders who demonstrate significant pathology and social/relational instability.
- Individuals diagnosed with mental retardation and/or borderline intellectual functioning who demonstrate the need for habilitative (skill maintenance) vs. rehabilitative (recovery-oriented) services.
- Individuals for whom primary treatment issues are related to substance abuse and/or dependence.
- Individuals who have a history of malingering.
- Individuals who have a diagnosed organic brain syndrome limiting prognosis for treatment outcomes (i.e.: dementia, stroke, significant brain trauma, etc.)

To help us determine whether this individual meets state defined and best practice criteria for ACTT services, please answer the following based on the information you have available:	
□ Yes □ No	This individual is currently eligible for Medicaid in Orange, Person or Chatham County.
□ Yes □ No	This individual is experiencing a severe and persistent mental illness that seriously impairs their ability to function in the community.
□ Yes □ No	He/she is unable to consistently perform the range of practical daily living tasks required for basic adult functioning in the community.
□ Yes □ No	This individual has difficulty maintaining consistent employment at a self sustaining level or difficulty carrying out head of household responsibility.
□ Yes □ No	He/she is unable to maintain a safe living situation.
□ Yes □ No	There is a history of frequent, acute psychiatric hospitalizations (2+ admissions/year)
□ Yes □ No	This individual is also diagnosed with a co-occurring substance use disorder
□ Yes □ No	This individual is at high risk for or has a recent history of criminal justice involvement
□ Yes □ No	This individual has a coexisting physical illness; disorders which exacerbate psychiatric symptoms.
□ Yes □ No	This individual is unable to meet basic survival needs or is residing in substandard housing, homeless or at risk of becoming homeless
□ Yes □ No	This individual is in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided.
□ Yes □ No	This individual requires a residential or institutional placement if more intensive services are not available.
□ Yes □ No	This individual has had difficulty effectively using traditional office-based outpatient services.
□ Yes □ No	This individual has received services at a less intensive level of care but functioning continues to be seriously impaired.

LUTHERAN SERVICES CAROLINAS

ACTT Referral Form

Client Name:	Date of Birth:
Medicaid # or IPRS:	County of Medicaid:
Social Security #:	MCO ID #:
Address:	Home #: Mobile #:
Client Entitlements (SSI, SSDI, etc.)	Residing County
Does this person have a legal guardian? If so, who?	Does this person have a representative payee? If so, who?
Primary language spoken in home:	Housing status (type and who do they live with):
Referring Staff Name and Agency:	Referring Agency phone #: Fax #:

Medical History

Please provide as much information regarding psychiatric and medical history as possible

Current psychiatric care provider: Dr. _____ Clinic/Practice name and address:	Current primary care provider: Dr. _____ Clinic/Practice name and address:
Psychiatric diagnoses (include DSM-V codes):	Current/recurrent medical diagnoses:

Psychiatric Provider History

Please provide as much information as possible

Is the client currently using any outpatient services? ☐ Yes ☐ No If *Yes*, please provide details:

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Name of Service:			
Contact name:		Telephone #	
Is the client currently in a hospital? ☐ Yes ☐ No Has the client had any psychiatric and or medical hospitalizations in the last 5 years? ☐ Yes ☐ No			
Date admitted:		Facility/outpatient service:	
Date discharged:			
Date admitted:		Facility/outpatient service:	
Date discharged:			
Date admitted:		Facility/outpatient service:	
Date discharged:			
Current Medications (including injections and date of last administration):			
Pharmacy name:		Telephone #	
Why does client need services at this time?			

Please attach the following documentation for this referral:

- CCA or admission assessment
- Discharge summary(s)
- Physician's order/medication history sheet
- Most recent PCP/ISP
- Most recent psychiatric evaluation or neuropsychiatric evaluation
- 6 most recent service notes

Questions? *Contact Toby Prenoveau, MS, CBIS, Intake Coordinator at 919-960-1157, tprenoveau@lscarolinas.net*

Fax completed referral and supporting documentation to 919-861-2891