Compass Health

HIT SERVICES EXTERNAL REFERRAL FORM – COMMUNITY PARTNERS

Before completing this form, please see the admission criteria for HIT services on the last page.

Date of Referral:

Client Information:

Client Name:	Client DOB:
Interpreter Services Needed? ☐ No ☐ Yes – Specify Language:	
Does Client have Medicaid? ☐ No ☐ Yes ProviderOne ID #:	Does Client have a Spenddown? ☐ No ☐ Yes

County Requested for HIT Services:

☐ Skagit ☐ Island ☐ Snohomish ☐ Whatcom

Additional Information:

Address (or name of current placement):	Last Agency to Provide Ongoing Services:
	☐ Closed ☐ Currently Open
Referral Source: ☐ WSH ☐ Local jail ☐ AIR ☐ LTR _____ ☐ MCO _____ ☐ Hospital: _____ ☐ Other, specify: _____	
Individual Completing Referral (print) _____	
(signature): _____	
Contact Phone:	E-mail:

Diagnosis: (Complete all w/ description / code. Please INCLUDE Substance Use Disorders)

	Code:
	Code:
	Code:

Please explain the need for HIT level of services, including symptoms experienced and impact on client, barriers to stability and risk.

Why is the current level of care unable to meet individual's needs?

How would HIT provide more support than what us being offered?

What isn't working with their current treatment?

Provide current Treatment Plan ☐ Yes ☐ No

Does the individual have stable housing? ☐ Yes ☐ No

Describe any concerns that impact housing access or housing stability.

Is the Individual on Housing waiting lists? ☐ Yes ☐ No

If Yes, where: _____

Does the individual require regular follow up? ☐ Yes ☐ No

History of Hospitalizations and Law Enforcement Contacts

(Please complete even if admission criteria in these areas are not met)

Psychiatric hospitalizations for the last 2 years

Hospital Name & Location *(if known*	ITA/Voluntary	Admission Date	Discharge Date

Other relevant information regarding hospitalizations, if any:

All known legal contact (incarcerations, arrests or other law enforcement contacts), with details as available.

Date of Arrest	Facility Name, Location, City & State	Incarceration Date	Release Date	Charge(s)/Description of Contact

Are there any outstanding legal matters? CPS, Civil, Criminal ☐ Yes ☐ No

If Yes, please provide the following:

_____

_____

Upcoming Court Dates _____

Does the current Case Manager assist with transportation or are they involved in any way? ☐ Yes ☐ No

Does the individual have natural supports? ☐ Yes ☐ No

Formal Supports? ☐ Yes ☐ No

Name & Phone number of those supports: _____

Is the individual on an LRA ☐ Yes ☐ No

If Yes, when does it expire (Date): _____

Does the individual have a Primary Care Provider? ☐ Yes ☐ No

Do they have any outstanding issues that need to be addressed immediately? ☐ Yes ☐ No

If, Yes, please provide information:

Medications:

_____

Current Psychiatric prescriber: _____ **Phone:** _____

Address _____

Fax _____

To be completed by individual referred: (adult programs)

☐ I agree to receive services from the specified program:

Client Signature: _____ **Date:** _____

☐ Client has been educated about the program and agrees to participate in the specified service but is not willing to sign the form

Admission Criteria

Admission Criteria (Mark all that apply)

*The client experiences continuous high service needs due to mental illness as demonstrated by **at least two** of the following:*

- ☐ Moderate to high use of psychiatric hospitals (e.g. in the past year, two or more admissions of more than 72 hours duration, or 30 or more total days, or a single stay of 21 or more days)
- ☐ Persistent, recurrent, or severe major symptoms
- ☐ Recent and/or recurrent criminal justice involvement
- ☐ Significant difficulty meeting basic survival needs, currently residing in substandard housing, or homelessness
- ☐ At imminent risk of becoming homeless (repeated evictions and/or currently on eviction notice)
- ☐ Residing in a supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided.
- ☐ Requiring more intensive services to preclude residential placement.
- ☐ History of medication or treatment non-compliance.

AND

*The client experiences significant functional impairments due to mental illness as demonstrated by **at least one** of the following conditions. This functional impairment is not attributed to dementia, pervasive developmental disorder, substance use disorder, or any other medical condition:*

- ☐ Significant difficulty in performing activities of daily living or significant difficulty except with significant support from others.
- ☐ Significant difficulty maintaining consistent employment at as self-sustaining level.
- ☐ Significant difficulty maintaining a safe living situation.

Email completed form to HITReferrals@compassh.org