CENTRAL FLORIDA CARES FACT REFERRAL FORM

Name of person referred: _____ SS#_____ DATE_____

Referral Source: _____ NEFSH _____NFETC _____FS _____TCSFH

Other Referral Source:_____

THIS SECTION TO BE COMPLETED BY REFERRAL SOURCE OR FACT TEAM

____ 1. Diagnosis within one of the following categories: Schizophrenia and other psychotic disorders (295 series); Mood Disorders (296 Series); Anxiety Disorders (300 Series); and Personality disorders (301 Series).

_____2. NO primary diagnosis of substance abuse disorder or mental retardation (IQ <70)

_____3. Meet ONE of the following three criteria:

- ____ a. Demonstrates a high risk for hospital admission or readmission
- ____ b. Have prolonged inpatient days (> 90 days) or
- ____ c. Have repeated crisis stabilization admissions (> 3)
- _____ d. AND meet at least three of the following six characteristics:
  - ____ 1. Inability to consistently perform the range of practical daily living tasks required for basic adult interactional roles in the community (e.g. maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs; obtain medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions) or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others.
  - _____ 2. Inability to be consistently employed at a self-sustained level or inability to Consistently carry out the homemaker role (e.g. household meal preparation, laundering clothing, budgeting or child care tasks and responsibilities).
  - _____ 3. Inability to maintain a safe living situation (repeated evictions, loss of housing, or no housing.
  - ____ 4. Coexisting substance abuse disorder of significant duration (greater than six months).
  - _____ 5. Destructive behavior to self or others.
  - ____ 6. High risk or recent history of criminal justice involvement (arrest and incarceration)

____4. Extenuating circumstances not covered by the above criteria (attach explanation).

THIS SECTION TO BE COMPLETE BY THE FACT TEAM

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FACT Staff processing referral: _____ _____ Screening completed: ____Y ___N

_____ Clinical documentation of disorder

____ Psychosocial evaluation submitted

___ _ Medical documentation of disorder

_____ Psychiatric evaluation submitted

_____ Consent to release information completed

_____Miscellaneous:_____

_____

_____

_____

Admission Date to FACT program: _____ County Served:_____

THIS SECTION TO BE COMPLETED BY THE MANAGING ENTITY

ME Staff:_____ Signature: _____
(Print Name)

Date: _____ _____ ADMISSION APPROVED ____ ADMISSION DENIED

IF DENIED, PLEASE GIVE REASONS: _____

_____

_____

_____

_____