# REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

## SECTION A: To Be Completed By the Health Plan Medical Director or Attending Physician

CLIENT NAME ______________________________ ☐ MALE ☐ FEMALE
Last First M.I.

HOME ADDRESS ______________________________ PHONE NO. ______________________________

______________________________ CASE NO. ______________________________

MAILING ADDRESS ______________________________ CLIENT ID NO. ______________________________

______________________________ SOCIAL SECURITY NUMBER ________________

DATE OF BIRTH ____________________ AGE _________ COUNTY ☐ OAHU ☐ HAWAII ☐ MAUI ☐ KAUAI

HEALTH PLAN: ☐ UNITEDHEALTHCARE COMMUNITY PLAN ☐ OHANA ☐ OTHER: __________

**PRIMARY DIAGNOSIS** ______________________________ DSMIV CODE _____________

**SECONDARY DIAGNOSIS** ______________________________ DSMIV CODE _____________

CURRENT MEDICAL CONDITIONS (Indicate, if none) ______________________________

______________________________

DATE OF REFERRAL: ____________________ NAME OF PCP: ______________________ PCP NOTIFIED: Y / N

| **HOSPITALIZATIONS** | **CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** ____________________ *(list)*<br>**Admitted on** _______/_______/________ | | | |
|---|---|---|---|---|
| Past Hospitalizations- Facility | Location | Date Admitted | Date Discharged | Diagnosis |
| | | | | |
| | | | | |
| | | | | |
| **MEDICATIONS** | Strength | Dosage | Start Date | End Date |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **OUTPATIENT THERAPISTS** | Diagnosis | | Start Date | End Date |
| | | | | |
| | | | | |

## Section B: To Be Completed By MQD/CSO Evaluation Panel

Date of Evaluation _______________ Date of Enrollment/Disenrollment of CCS

Services__________________________________

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed

Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments ______________________________

______________________________

Signature: ______________________________

**FOR ADULTS ONLY**

Client Name: ______________________________ Client I.D. No.: __________________

## SECTION C: To Be Completed By the Health Plan Medical Director or Attending Physician

### I. MENTAL STATES

**A. General:**

1. Appearance: Within normal limits [ ] Other [ ] ______________________________
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs improvement [ ]

**B. Behavior:**

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] __________
3. Body Movements: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] __________

**C. Speech:** Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] ______________________________________________

**D. Mood:** Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] ______________________________________________

**E. Affect:** Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]
Other [ ] ______________________________________________

**F. Thought:**

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ]
Thought insertion [ ] Thought withdrawal [ ] Other [ ] __________________

**G. Perception – Hallucinations:**

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] __________________

**H. Reality Orientation:**

1. Mark all areas which the recipient can name:
Time: Day [ ] Month [ ] Year [ ]
Place: (can describe location) Yes [ ] No [ ]
Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] No [ ] Remote intact: Yes [ ] No [ ]

**I. Insight:** Aware of illness [ ] Denies illness [ ] Other [ ] __________________

**J. Judgment:** Good [ ] Fair [ ] Poor [ ]

## FOR ADULTS ONLY

Client Name: ______________________________________ Client I.D. No.: __________________

## II. FUNCTIONAL SCALES: *(Check and specify any problem(s) in the following areas)*

[ ] **Medical/Physical**

________________________________________________________________________

________________________________________________________________________

[ ] **Family/Living**

________________________________________________________________________

________________________________________________________________________

[ ] **Interpersonal Relations**

________________________________________________________________________

________________________________________________________________________

[ ] **Role Performance**

________________________________________________________________________

________________________________________________________________________

[ ] **Socio-Legal**

________________________________________________________________________

________________________________________________________________________

[ ] **Self-Care/Basic Needs**

________________________________________________________________________

________________________________________________________________________

## SECTION D: To Be Completed By the Attending Physician

**III. SUPPORTING DOCUMENTATION:** Please provide additional comprehensive information and assessments (if available) to assist in the evaluation of the criteria for CCS eligibility.

Signed: ___________________________________________________ Date: __________________

Reporting Psychiatrist/Psychologist *(Print Name)*: ____________________________________________

Reporting Psychiatrist/Psychologist Phone No.: ____________________________________________

Signed: ___________________________________________________ Date: __________________

Medical Director or Attending Physician for in-patients *(Print Name)*: __________________________