

PACT Team Referral

First name: _____ Middle Initial: _____ Last Name: _____

Maiden Name: _____ DOB: _____ SS#: _____

Address: _____ Phone: _____

Other contact information: _____

Medicaid #: _____ Medicare #: _____ SSI ____ SSDI ____

Allergies and/or Medical Conditions: _____

Referral Sent(X):	Counties Served	Agency	Phone	Fax
	Pontotoc, Garvin, Murray (Ada)	CACMHC	580-332-3699	580-421-9828
	Oklahoma	Red Rock	405-425-0341	405-425-0313
	Oklahoma	North Care	405-810-9578	405-808-1775
	Tulsa	Family & Children's	918-599-7404	918-584-2530
	Tulsa- CO-PACT	Family & Children's	918-582-7228	918-382-1881
	Tulsa-IMPACT	University of Oklahoma	918-660-3150	918-660-3143
	Pottawatomie, Seminole (Shawnee)	Red Rock	405-878-1135	405-878-1138
	Coal, Atoka, Pittsburg, Latimer (McAlester)	Carl Albert CACMHC	918-426-7854	918-426-1576
	Cleveland, McClain (Norman)	Central Oklahoma (COCMHC)	405-573-3955	405-573-3966
	Comanche, Cotton (Lawton)	Jim Taliaferro JTCMHC	580-248-5436	580-248-9128
	Payne (Stillwater)	Edwin Fair	580-332-3699	580-421-9828
	Kay (Ponca City)	Edwin Fair	580-763-0931	580-763-0934

Sending any records from your facility with your referral will help us determine eligibility. Without records we must first obtain a Release of Information and request records which could delay the process.

Priority shall be given to those with a primary diagnosis of Schizophrenia, Schizoaffective disorder or Bipolar with psychotic features. Individuals with a primary diagnosis of substance abuse, brain injury or Axis II disorders are not appropriate for PACT.

Diagnosis - Include substance abuse/dependency

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Admission Criteria

4 psychiatric hospitalizations in the past 24 months or lengths of stay *totaling* over 30 days in the past 12 months. Time spent in jail, prison and/or residential care facilities will be considered.

Hospital/Jail/RCF	Admit Date	Discharge Date	Reason for admission
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____

Must meet 3 of the following:

- ___ Persistent or recurrent severe affective, psychotic or suicidal symptoms
- ___ Homeless, imminent risk of losing housing or living in substandard/unsafe housing OR residing in supported housing but clinically assessed to be able to live in a more independent living situation if intensive services are provided.
- ___ High risk of or criminal justice involvement in the past 12 months (please list arrest/release date and place)

_____ Probation? _____ Parole? _____
- ___ Inability to consistently perform the range of practical daily living tasks required for basic adult functioning
- ___ Inability to participate in traditional office-based services
- ___ Co-existing substance abuse disorder greater than 6 months – Drug(s) of choice: _____
- History of Violent/Aggressive Behavior: _____

- Symptoms & Behavioral Challenges (risk of harm to self or others, etc): _____

- Other issues affecting treatment. (Substance use w/drug of choice, employment, and family involvement): _____

- Physical Health Issues: _____

Please note: this referral may be forwarded to the PACT program designated to serve the consumer's respective service area.

- Please attach a copy of the latest psychiatric evaluation and other pertinent information that may be helpful.
- **Attach Releases of Information for ALL prior hospitalizations.**
- Referrals which don't contain all releases and information needed may take longer to process.
- Please phone the team if you have questions regarding the referral process.
- Out of courtesy, please indicate ALL teams you have sent the referral to so we may collaborate on the effort.

Referred By: _____ Agency: _____ Date: _____

Phone: _____ Email: _____ Fax: _____