EMERGENCY ROOM
ENHANCEMENT
Improving Access to Behavioral Health Care

Referral Form

Region:		Date of Referral:
Participant Name (LAST, FIRST, MI):		
DOB:	SSN:	DCN:
Street Address:		
City:	State:	ZIP:
Phone:		Email:
Referred From:		
Referred To:		
Sex:		Ethnicity:
Race:		Military Status:
Housing Status:		Employment Status:
Payer Source:		
Was there Law Enforcement Involvement for this Referral?		
Primary Reason for this Referral?	If other, please specify:	
Primary Mental Health Concern at Referral?		
Primary Substance Use Concern at Referral?		
Primary Physical Health Concern at Referral?		
Is individual deaf/hard of hearing?		
Program Eligibility:		
MHCPP Referral:		
MHCPP Referral Notes:		
Notes from Referral Source:		

Updated 08/16/2016

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Individual History and Needs Assessment

Region:		Date of Assessment:
Participant Name (LAST, FIRST, MI):		
DOB:	SSN:	DCN:
Sex:		Ethnicity:
Race:		Military Status:
Housing Status:		Employment Status:
Payer Source:		
Is individual currently on probation or parole?		

Mental Health History (Check all that apply):		
ADD/ADHD	Alzheimer's	Antisocial Personality Disorder
Autism Spectrum Disorder	Bipolar Disorders	Borderline Personality Disorder
DD/Intellectual Disability	Delusional	Dementia
Depression	Eating Disorder	OCD
Panic/Anxiety	PTSD	Schizophrenia/Schizoaffective Disorder
Sleep Disorder	Other – Psychotic Disorder	Other - mark and specify below
No Mental Health History		

Substance Use History (Check all that apply):		
Alcohol	Cocaine	Hallucinogens
Heroin	Inhalants	Marijuana
Methamphetamine	Prescription Opioids	Prescription Sedatives
Prescription Stimulants	Synthetic Drugs	Other - mark and specify below
Unknown Substance(s)	No Substance Use History	

Physical Health History (Check all that apply):		
BMI>25	Chronic Pain	Congestive Heart Failure
COPD/Asthma	Dental Pain	Diabetes
Hepatitis C	Tobacco Use	Other - mark and specify below
No Physical Health Issues		

Program	Need Identified
Community-based Assistance	
Crisis Services	
Dental Care	
Developmental Disabilities Services	
Employment Services	
Food Assistance	
Housing	
Mental Health Services	
Payer Assistance	
Physical Health Services	
Psychiatry	
Substance Use Services	
Transportation Assistance	
Medication Assistance	
Basic Needs Assistance	
Legal Assistance	

Number of: Emergency Room visits in past 3 months	
Hospitalizations in past 3 months	
Law enforcement contacts in past 3 months	

DLA-20© mGAF score at time of IHNA	
Date of DLA-20© mGAF score	

Program Eligibility after IHNA:	
MHCPP Eligibility after IHNA:	

Notes:

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Three Month Follow Up

Region:	Date of Follow Up:	
Participant Name (LAST, FIRST, MI):		
DOB:	SSN:	DCN:
Is individual still actively engaged in ERE services?		

Housing Status at Follow Up:	
Employment Status at Follow Up:	
Payer Source at Follow Up:	

Program	Need Identified	Referred to or Engaged with Resources	Need is met or stable at 3 mos	
Community-based Assistance				
Crisis Services				
Dental Care				
Developmental Disabilities Services				
Employment Services				
Food Assistance				
Housing				
Mental Health Services				
Payer Assistance				
Physical Health Services				
Psychiatry				
Substance Use Services				
Transportation Assistance				
Medication Assistance				
Basic Needs Assistance				
Legal Assistance				

Number of:		
	Emergency Room visits in past 3 months	
	Hospitalizations in past 3 months	
	Law enforcement contacts in past 3 months	

DLA-20© mGAF score at time of Follow Up	Date of DLA-20© mGAF score	

Notes:

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Six Month Follow Up

Region:	Date of Follow Up:
Participant Name (LAST, FIRST, MI):	

DOB:	SSN:	DCN:
Is individual still actively engaged in ERE services?		

Housing Status at Follow Up:
Employment Status at Follow Up:
Payer Source at Follow Up:

Program	Need Identified	Referred to or Engaged with Resources	Need is met or stable at 3 mos	Need is met or stable at 6 mos
Community-based Assistance				
Crisis Services				
Dental Care				
Developmental Disabilities Services				
Employment Services				
Food Assistance				
Housing				
Mental Health Services				
Payer Assistance				
Physical Health Services				
Psychiatry				
Substance Use Services				
Transportation Assistance				
Medication				
Basic Needs Assistance				
Legal Assistance				

Number of: Emergency Room visits in past 3 months	
Hospitalizations in past 3 months	
Law enforcement contacts in past 3 months	

DLA-20© mGAF score at time of Follow Up	Date of DLA-20© mGAF score	

Notes:

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Transition Form

Region:	Date of Transition:

Participant Name (LAST, FIRST, MI):		
DOB:	SSN:	DCN:

Date of last contact:	
Housing Status at last contact:	
Employment Status at last contact:	
Payer Source at last contact:	

Reason for Transition:	

Program	Need Identified	Referred to or Engaged with Resources	Need is met or stable at last contact	
Community-based Assistance				
Crisis Services				
Dental Care				
Developmental Disabilities Services				
Employment Services				
Food Assistance				
Housing				
Mental Health Services				
Payer Assistance				
Physical Health Services				
Psychiatry				
Substance Use Services				
Transportation Assistance				
Medication Assistance				
Basic Needs Assistance				
Legal Assistance				

DLA-20© mGAF score at time of last contact	Date of last DLA-20© mGAF score

Notes: