McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

# Program of Assertive Community Treatment (PACT) Referral Form

Please download this form before filling it out.
Please fax to **781.209.6800**, Attn: PACT Referral Coordinator, Audrey Murphy

**Date:** _____

## Demographics:

**Client Name:** _____ **Client Phone Number:** _____
**Client Email:**_____ **DOB:** _____ **Age:** ____ **Sex:** ____
**Preferred Pronouns:** _____ **Marital Status:** _____
**Client Preferred Method of Contact (phone/email/text):** _____
**Address (include name if it is an organization):** _____
_____
**Commute time between McLean and where they reside (from Google Maps):**_____
**Lives with:**_____
**How long has person resided there?:** _____
**Primary Family/Emergency Contact Name:**_____
**Primary Family/Emergency Contact Phone Number:** _____
**Primary Family/Emergency Contact Email:**_____
**Guardian Name and Phone Number (If applicable):**_____
**Does the client drive/have access to a vehicle?** _____

## Referral Information

**Name of person completing this form:** _____ **Phone number:**_____

**Email:** _____ **Relationship to client:** _____

**If applicable, indicate clinic/institution:** _____

**Reason for referral at this time (Select all that apply):**

☐ **No mental health care**
☐ **Has services, needs higher level of mental health support**
☐ **Has multiple psychiatric admissions in the past 6 months**
☐ **Unsuccessful in other levels of care**
☐ **Other:** _____

**Is person interested in PACT services?** ☐ **Yes** ☐ **No**

**If no, why?** _____

**Is the family/support system interested in PACT services?** ☐ **Yes** ☐ **No**

**If no, why?** _____

## Current Clinical Information

**Current Clinical Presentation (predominant symptoms):**

_____

_____

_____

_____

**Is person currently experiencing psychosis?** ☐ **Yes** ☐ **No**

**Current Diagnosis (can list multiple):**

_____ _____

_____ _____

_____ _____

_____ _____

**Current Medications (please include name, dose):**

_____ _____

_____ _____

_____ _____

_____ _____

**Does person take these as prescribed?** ☐ **Yes** ☐ **No**

**If no, what are the barriers?** _____

**Current Medical Issues:**

_____ _____

_____ _____

_____ _____

_____ _____

**Current Substance Use:**

| Substance | Frequency of Use |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Is the person currently engaged in any treatment?** ☐ **Yes** ☐ **No**

**If no, what are the barriers to engagement?** _____

_____

_____

**If yes, what services are they currently engaged in? (please select all that apply)**

| | Provider Name | Organization (Location) | Phone/Fax |
|---|---|---|---|
| ☐ Psychopharm | | | |
| ☐ Therapy | | | |
| ☐ DMH | | | |
| ☐ VNA | | | |
| ☐ Day Structure | | | |
| ☐ Substance Abuse | | | |
| ☐ Residential | | | |
| ☐ Other: _____ | | | |

**Does this person currently have any of the following? (Please select all that apply. If yes, please provide more detail):**

☐ **Suicidal ideation:** _____

☐ **Homicidal ideation:** _____

☐ **Access to weapons:** _____

☐ **Guns in their home:** _____

☐ **Aggression/violence:** _____

## Historical Clinical Information

**Prior levels of care engaged in (please select all that apply):**

☐ **Psychiatric inpatient**
☐ **VNA**
☐ **DMH (please indicate which services):** _____
☐ **Residential/group home (if known, please indicate the name):** _____
☐ **Continuing care (state hospital)**

**Number of prior (lifetime) psychiatric inpatient admissions:** _____

**Most recent psychiatric inpatient admission (date and name of facility):** _____

**Has this person ever had any of the following (Please select all that apply. If yes, please provide more detail with date if known):**

☐ **Psychosis:** _____

☐ **Suicidal ideation:** _____

☐ **Suicide attempts:** _____

☐ **Homicidal ideation:** _____

☐ **Access to weapons:** _____

☐ **Guns in their home:** _____

☐ **Aggression/violence:** _____

**Has this person ever been arrested, charged, or convicted of anything?** ☐ **Yes** ☐ **No**

**If yes, please provide more detail and dates if known:**_____

_____

_____

**Please provide name of probation officer if applicable:** _____

**History of Substance Use:**

| **Substance** | **Last Date of Use (If known)** |
|---|---|
| | |
| | |
| | |
| | |

**History of trauma (please indicate type, person's age when it occurred and pertinent details if known):** _____

_____

_____

## Psychosocial Functioning

**Family involvement and family dynamic:** _____

_____

_____

_____

_____

**Is there any domestic violence that you are aware of?** ☐ **Yes** ☐ **No**

**If yes, please provide more detail:** _____

_____

_____

**Other social supports or community involvement:** _____

_____

_____

**Is there a family history of mental illness?** ☐ **Yes** ☐ **No**

**Please indicate relation to person and their diagnosis:** _____

_____

_____

_____

_____

**Level of Education:** _____

**Employment/Occupation:** _____

**Primary Source of Finances:** _____

**History of Homelessness?** ☐ **Yes** ☐ **No** **If yes, when were they last homeless?** _____

## Finances

**Who will be responsible for financing PACT services:** _____

**Email address of person financially responsible:** _____

**Has the person responsible for finances been informed of the financial expectation?** ☐ **Yes** ☐ **No**

## Referrer Recommendations

**How many months do you estimate this person needing PACT level of services?** _____

**Please select the top 5 types of PACT services that the person would benefit from the most:**

| | | |
|---|---|---|
| ☐ **Psychopharmacology** | ☐ **Individual Therapy** | ☐ **Social/Interpersonal Coaching** |
| ☐ **Psychoeducation** | ☐ **24/7 Crisis Support** | ☐ **Vocational Support** |
| ☐ **Medication Management** | ☐ **Community Integration** | ☐ **Wellness Coaching** |
| ☐ **ADLs Coaching** | ☐ **Substance Use** | ☐ **Family Psychoeducation/Coaching** |

**Preferred start date:** _____

## Submit Form

Please complete and submit the referral form by fax to **781.209.6800**, Attn: PACT Referral Coordinator, Audrey Murphy, or by mail to:

McLean Hospital
Attn: PACT
115 Mill Street
Belmont, MA 02478

Please attach any pertinent records (i.e., demographic sheet, copy of insurance card, admission/ intake notes, psychosocial assessments, discharge summary, medication list, and recent progress notes).

With any questions, please contact Referral Coordinator, Audrey Murphy at 781.227.0551

**For Staff Use Only: Appropriate for McLean PACT at this time?** ☐ **Yes** ☐ **No**