CENTRAL OHIO MENTAL HEALTH CENTER
SAMI/ACT Admission & Referral Worksheet

Client Name: _____ **Client ID #:** _____

Referral To: ☐ **SAMI/IDDT Team** **Date Referred:** _____

1. Is the Client 18 Years or older? ☐ **Yes** ☐ **No**

2. Is there a Primary, non-SMD Mental Health Diagnosis of Anxiety, Major Depression w/o psychotic features, Panic, Agoraphobia, PTSD, Somatoform disorders or Depressive disorder NOS? ☐ **Yes** ☐ **No**
If Yes, Specify: _____

3. Primary Drug/Alcohol Diagnosis? ☐ **Yes** ☐ **No**
If Yes, Specify: _____

4. Are Hallucinations, Delusions, Disorganized Thought Patterns, Bipolar or Major Depressive Symptoms Present? ☐ **Yes** ☐ **No**

5. Does the Client agree to an Admission or Transfer to the Team? (NOT AN EXCLUSIONARY CRITERIA) ☐ **Yes** ☐ **No**

6. Does the Client have a moderate to major functional impairment in one of the following areas? ☐ **Yes** ☐ **No**

a. Activities of daily living
- Self Care: maintaining living space, adequate nutrition, personal hygiene, health care, clothing.
- Instrumental: inability to use available transportation and manage finances.

b. Employment, education and/or homemaking
c. Social/Community/Interpersonal Functioning

7. Does the Client meet criteria for two or more of the following indicators of continuous high service needs? (please circle letter of criteria client meets). ☐ **Yes** ☐ **No**

a. Two or more acute psychiatric hospitalizations or one extended psychiatric hospitalization of more Than 21 days within past three years.
b. High use of psychiatric emergency services as evidenced by 10 or more emergency contacts in past 12 months.
c. Intractable symptoms.
d. Co-occurring substance use disorder or co-occurring mental retardation (specify:_____).
e. Involvement in Criminal Justice System (including NGRI & Conditional Release)
f. Other services failed to engage and/or stabilize consumer.
g. Consumer has demonstrated high-risk behavior in the past year, and provider believes that ACT/SAMI is essential in reducing risk of harm to consumer and/or the community.
h. The person requires ACT/SAMI services to move out of an institutional environment (i.e. nursing home, prison, jail, adult care facility).
i. The person has high medical needs and, due to mental illness, requires assistance to manage them (ACT).

IF "YES" TO ALL ABOVE QUESTIONS, CONSIDERATION WILL BE GIVEN FOR SAMI OR ACT TEAM

Referring Staff's Signature: _____ **Date:** _____

CRITERIA FOR NOT ADMITTING/TRANSFERRING TO THE TEAM

A. Current Team caseload size exceeds the acceptable limit? ☐ **Yes**

B. Client carries a primary Axis II diagnosis? ☐ **Yes**

C. Client does not meet the Mental Health Diagnostic criteria? ☐ **Yes**

D. Other: _____ ☐ **Yes**

_____

Referral Disposition:

☐ **Client Admitted to SAMI Team** ☐ **Client NOT Admitted to SAMI Team**

☐ **Client Admitted to ACT Team** ☐ **Client NOT Admitted to ACT Team**

_____

_____

_____

Copy of Disposition given to Referring Staff: ☐ **Yes** ☐ **No**

Staff Signature/Credentials: _____ **Date:** _____