SAMI Referral Screening Form

(To be completed by transferring clinician)

Client Name _____ **Case #** _____

(Please bring DA and/or chart with this completed form to SAMI Coordinator)

SMD Axis I Diagnosis

(Schizophrenia, Schizoaffective, Bipolar I, or Major Depression w/ psychotic features with evidence symptoms reported/observed are not substance-induced)

Specify (including DSM code): _____

_____

Substance Abuse or Dependence Diagnosis

Specify: _____

Severe Functional Impairment

(occupational, social, relational, other)

Specify: _____

_____

_____

_____

Difficulty/Inability to Independently Access Resources in Community

(i.e. CPST medical necessity--due to severity of symptoms, not due to consequences of substance abuse alone)

Specify: _____

_____

_____

_____

Stage of Treatment: MH: _____ AOD: _____

(Engagement, Persuasion, Active Treatment, Relapse Prevention, Remission)

Paperwork up to date in chart:

Last DA/DA Update date of completion: _____

ISP/6month dates: _____

Consumer Outcomes date: _____

Transfer form completed: _____