NEIGHBORING: DUAL DIAGNOSIS PROGRAM

ADMISSION AND REFERRAL WORKSHEET

Client Name: ____ **Client ID#** ____________

Referral Source : ____________________________________ **Date Referred:** _________

1a. Is there a Primary Severe and Persistent Mental Illness? YES NO
(As evidenced by clear documented history of MH Tx and/or symptoms and impaired functioning)

-----------OR------------

1b. Is there a Primary, non-SMD Mental Health diagnosis of one of the following: YES NO
- Major Depressive Disorder, Recurrent, Moderate
- Panic Disorder
- Post-Traumatic Stress Disorder
- Severe Eating Disorders
- Severe Anxiety Disorder (OCD, GAD)
- Severe Personality Disorders

2. Primary Moderate to Severe AoD Diagnosis? YES NO
If Yes, Specify ____

3. Are Hallucinations, Delusions, Disorganized Thought Patterns, Severe Manic or Vegetative symptoms present? YES NO

4. Does the client agree to admission/transfer to the Program? *(NOT EXCLUSIONARY)* YES NO

5. Does the client have a moderate to severe functional impairment in any of the following areas: YES NO
- ☐ *Activities of Daily Living*
  - ☐ Self-Care – maintaining living space, adequate nutrition, personal hygiene, health care, clothing
  - ☐ Instrumental – inability to use available transportation & manage finances
- ☐ *Employment, Education or Homemaking*
- ☐ *Social / Community / Interpersonal Functioning*

6. Does the client meet criteria for *TWO or more* of the following indicators of continuous high service needs? YES NO
- ☐ Mental health symptoms were present prior to onset of substance use
- ☐ Two or more psychiatric hospitalizations or ONE extended psychiatric hospitalization of more than 21 days within the past three years?
- ☐ High use of psychiatric emergency services as evidenced by 10 or more Emergency contact within the last 12 months
- ☐ Intractable symptoms
- ☐ Involvement in the Criminal Justice System (including NGRI & conditional Release)
- ☐ Other services failed to engage and/or stabilize clients
- ☐ Consumer has demonstrated high-risk behaviors in the past year, and provider feels that DD Program is essential in reducing harm to consumer and/or community
- ☐ The person requires DD Program to move out of institutional environment
- ☐ The person has high medical needs and due to mental illness requires assistance to manage them.

IF "YES" TO ATLEAST 4 OF ABOVE QUESTIONS, CONSIDERATION WILL BE GIVEN FOR DD PROGRAM.

CRITERIA FOR NOT ADMITTING INTO DUAL DIAGNOSIS PROGRAM

A. Client does not meet Program Criteria **MH** **AoD**
EXPLAIN: ____
____

DISPOSITION:

☐ **Client ADMITTED to DD Program** ☐ **Client NOT ADMITTED to DD Program**

Staff Signature/Credentials: ____ **Date:** __________

(Copy of Disposition given to Referring Staff? YES NO)