

LOGO HERE

**Community Assistance, Recovery, and Empowerment (CARE) Act
BEHAVIORAL HEALTH - INTERNAL CARE ACT REFERRAL**

REFERRING PARTY INFORMATION

DATE:

NAME:

BH UNIT:

PHONE:

RESPONDANT (CLIENT) INFORMATION

RESPONDENT FIRST NAME

RESPONDENT LAST NAME

PREFERRED NAME

RESPONDENT'S PRIMARY PHONE

RESPONDENT'S SECONDARY PHONE

DATE OF BIRTH (MM/DD/YYYY)

RESPONDENT'S HOME/RESIDENCE ADDRESS/LAST KNOWN LOCATION

ELECTRONIC HEALTH RECORD ID

CLIENT CURRENTLY ACTIVE WITH – CHECK ALL THAT APPLY

ACM

ADS

AFSP

ADULT THERAPY

DIVERSION

MEDICATION CLINIC

OLDER ADULT MH

TAY

Partner 1

Partner 2

OTHER:

CRITERIA INFORMATION

Respondent has a diagnosis of a schizophrenia spectrum disorder or another psychotic disorder in the same class:

Select Disorder

or, Respondent has the following diagnosis:

[REVIEW CARE ACT CRITERIA HERE](#)

REFERRAL INFORMATION

PLEASE DESCRIBE THE SITUATION:

CLEAR FIELDS

SAVE FORM

BEHAVIORAL HEALTH - INTERNAL USE ONLY

SUBMIT REFERRAL