

# DMHAS ABI CONSULTATION REFERRAL

Return by Mail or Fax

To

DMHAS-ABI Community Integration Program

Beers Hall-P.O. Box 351

Middletown, CT 06457

Fax#860-262-5852

Revised 8/1/13

***NOTE: Asterisk areas Required to Process Referral***

Form 201		<b>Client Information</b>			
* <b>Client Name:</b>		Maiden Name:		* (circle) <b>M                      F</b>	
* <b>Address:</b>		<b>City:</b>		<b>St:      Zip:</b>	
		<b>Phone:</b>			
<b>Age:</b>	* <b>DOB:</b>	<b>Place Of Birth:</b>			<b>ROI    Yes    No</b>
<b>Race:</b>	<b>Religion:</b>	* <b>Ethnicity:</b>		* <b>Primary Language:</b>	
<b>Marital Status:</b>		* <b>Veteran Status:</b>		<b>Education (Highest Grade)</b>	
		<b>Yes / No</b>			
<b>DMHAS Client (circle)</b>		<b>Region</b>		<b>MPI #</b>	
<b>YES                  NO</b>				* <b>Social Security Number</b>	
<b>Employment Status:</b>			<b>Occupation:</b>		
<b>Employer(Name, Location, Phone):</b>					
<b>Income &amp; Insurance</b>					
<b>Type</b>		<b>I.D.</b>		<b>Amount</b>	
* <b>Conservator (circle answer)</b>					
* <b>Person</b>		* <b>Estate</b>		* <b>None</b>	
* <b>Name:</b>				* <b>Telephone</b>	
* <b>Address:</b>					
<b>Clinicians/Agency</b>					
<u>Current Programs</u>		<u>CLINICIANS/AGENCY</u>		<u>PHONE#</u>	
<b>Receiving Services from</b>					
<input type="checkbox"/> DMHAS		<input type="checkbox"/> YAS		<input type="checkbox"/> DCF	
<input type="checkbox"/> DOC		<input type="checkbox"/> Nursing Home		<input type="checkbox"/> DDS	
		<input type="checkbox"/> DSS			

### Clinical Information

\* **Person Making Referral:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\* **Agency:** \_\_\_\_\_ **\* Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

\* **Reason For Referral (Please be specific)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Consultation Services | <input type="checkbox"/> Advocacy                  | <input type="checkbox"/> ABI Substance Abuse       |
| <input type="checkbox"/> Housing               | <input type="checkbox"/> Assistance with Discharge | <input type="checkbox"/> ABI Vocational            |
| <input type="checkbox"/> Community Residence   | <input type="checkbox"/> ABI Verification          | <input type="checkbox"/> ABI Transitional Services |

\* **Explain:**  
 \_\_\_\_\_  
 \_\_\_\_\_

\* **Has this client sustained a brain injury? (Circle answer) See definition at end of form.**

Yes	No	Unknown
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If yes, please describe, (date, type, loss of consciousness, injuries, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Was the client hospitalized as a result? (Circle answer)	Yes	No	Unknown
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Where: \_\_\_\_\_

Have you requested medical records? (Circle answer)	Yes	No	When: _____
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History of Rehabilitation Services:  
 \_\_\_\_\_  
 \_\_\_\_\_

Psychiatric/Substance Abuse History:  
 \_\_\_\_\_  
 \_\_\_\_\_

Diagnoses (I -V): Diagnosed by: _____	Date of Diagnosis: _____
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Axis I:	Axis IV:
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Axis II:	Axis V:
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Axis III: \_\_\_\_\_

Medications:  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies:  
 \_\_\_\_\_

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**\*Client's Location at time of Referral:**

- Living independently in the community
- Homeless (Name of shelter if applicable: \_\_\_\_\_)
- Inpatient psychiatric facility (Potential Discharge Date: \_\_\_\_\_)
- Inpatient medical facility (Potential Discharge Date: \_\_\_\_\_)
- DOC/Corrections (Potential Discharge Date: \_\_\_\_\_)
- Nursing home (Potential Discharge Date: \_\_\_\_\_)
- Inpatient Substance Abuse

Presenting Problem:

**For DMHAS ABI Office Use Only**

Program Response

Date:

Receiving Staff:

Assigned Regions 1A 1B 2A 2B 3A 3B 4A 4B 5

**ABI/TBI DEFINITION**

***Any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed, at the brain stem level and above. This dysfunction is acquired through the interaction of an external force such as a blow to the head or violent movements of the body; oxygen deprivation; infection; surgery; or vascular disorders not associated with aging. This dysfunction is not developmental or degenerative in origin.***