Lehigh/Northampton Counties HealthChoices
ACT Transition Screening Tool

ACT REFERRAL AND SCREENING FORM

Date of Assessment: _____

(1) Current CTT Provider *(circle one)***:** Elwyn LV ACT NHS

(2) Gender *(circle one***):** Male Female

(3) Client Name: _____

(4) County: *(circle one)* Lehigh Northampton

(5) Date of Birth: _____

(6) Client Phone #: _____

(7) Social Security #: _____

(8) Pref Language: _____

(9) Current Housing: _____

(10) Client Address: _____

_____

(11) Daily Medication Drops *(circle one):* Yes No

(12) Injectable Medication *(circle one)***:** Yes No

(13) Current Presenting Problems: (describe)

_____

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(14) Consumer Eligibility for ACT:

PART 1: Must meet ALL the Criteria in Part 1 to be eligible for ACT *(Check (✓) if "yes")*		
Over 18 years of age	Yes	
Primary diagnosis of schizophrenia or other psychotic disorders (i.e. schizoaffective disorder, bipolar disorder as defined by DSM IV-R)	Yes	
Difficulty utilizing traditional cases management or office based outpatient services or evidence that they require more assertive and frequent non-office based service to meet their clinical needs	Yes	
Functional level: Current GAF Below 40	Yes	
Frequent Emergency Room Visits	Yes	
PART 2: Must meet two (2) out of the six (6) criteria in Part 2 to be eligible for ACT *(Check (✓) if "yes")*		
Two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months	Yes	
Intractable (persistent or very recurrent) severe major symptoms (affective, psychotic, suicidal)	Yes	
Co-occurring mental illness and substance use disorders more then six (6) months duration at the time	Yes	

High Risk or Recent history of criminal justice involvement which may include frequent contact with law enforcement personnel, incarcerations, parole or probation	Yes	
Homelessness	Yes	
Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring residential or institutional placement if more intensive services are not available	Yes	

(15) IQ of 80 or Higher (i.e. absence of mental retardation) **Yes** **No**

(16) DSM-IV IV DIAGNOSIS OF: (circle if Yes) (if likely but not definite, insert (?) in the appropriate box)

BI-POLAR DISORDER	**Yes**	☐	**SCHIZOPHRENIA**	**Yes**	☐
DELUSIONAL DISORDER	**Yes**	☐	**PSYCHOTIC DISORDER, NOS**	**Yes**	☐
SCHIZOAFFECTIVE DISORDER	**Yes**	☐	**OCD**	**Yes**	☐

(17) DSM-IV IV DIAGNOSIS OF: (circle all that apply)

Alcohol Use Disorder (Abuse or Dependence) **Yes**

Other Substance Use Disorder (Abuse or Dependence) **Yes** **(List substances abused)**_____

Decision to admit client into ACT: Yes No

COMMENTS:

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